Generations Care Medical

102-3211 152 St, Surrey BC. V3Z 1H8
ph: 604-260-6019 fax:844-444-0673
generationscare25@gmail.com

Patient Consent Form for Disclosure of Medical Information to a Designated Relative

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Address: _____

Designated Relative Information

Full Name: _____

Relationship to Patient: _____

Phone Number: _____

Address: _____

Purpose of Consent:

I, the undersigned hereby authorize (Generations Care Medical) and its healthcare providers to release and discuss my medical information with the above-named relative, **for the purpose of relaying health-related information to me in the event I am not physically present or unable to receive it directly**.

This may include, but is not limited to:

- Diagnosis and test results
- Treatment plans and progress
- Medication instructions
- Appointment details

Consent Terms:

- This consent **does not** authorize the designated person to make medical decisions on my behalf.
- This consent is **valid until revoked** in writing by me.
- I understand that I have the right to withdraw this consent at any time by providing written notice to the clinic.

Acknowledgment and Signature:

I understand the nature of this authorization and voluntarily provide my consent for the disclosure of my medical information under the terms described above.

Patient Signature: _____

Date: _____

Witness Name & Signature (if required): _____

Date: _____