

## Permission to Share Records

I, \_\_\_\_\_, give permission to  
(Patient)

\_\_\_\_\_ to have access to any of my  
(Spouse, Friend, Parent, Child, Etc.)

medical records from "North Valley Internal Medicine".

Date: \_\_\_\_\_

Patient's Signature: \_\_\_\_\_

Print Name: \_\_\_\_\_

Witness's Signature: \_\_\_\_\_