Disclosure of Information
Space Coast Psychiatry, Inc.

Client Name: _______________________________ DOB: ____________________

Patient acknowledges and agrees that Space Coast Psychiatry and its staff, may disclose the Patient's protected health information and patient medical record information to the following individuals who are either the Patient's family members, legal representatives, guardians, health care surrogates, or have power of attorney on behalf of the Patient.

Please list the name and relationship to Patient:

Name: ____

Relationship: ____

Name: ____

Relationship: ____

Name: ____

Relationship: ____

Name: ____

Relationship: ____

****

Client Signature, or Parent/Guardian, if under 18: ___________________________

Print Name: ________________________________ Date: ________________