**St John Center for Wellness and Family Medicine**
18303 Ten Mile, Suite 500
Roseville, MI 48066

I, _____
(print name)

authorize St John Center for Wellness and Family Medicine to share any and all of my medical records with the following individual until revoked in writing:

Print name of person to whom disclosure is to be made:

_____

Relationship to Patient: _____

Patient Signature: _____

Date of Birth: ___/___/_____ Date: ___/___/_____

*this form gives permission to the providers and staff of St John Center for Wellness and Family Medicine to share your personal heath information with the above name. This can include but is not limited to test results and messages from the office.