California Center for
Reproductive Health

16550 Ventura Blvd., Suite 400, Encino, CA 91436

CONSENT FOR SHARING OF MEDICAL INFORMATION

DATE: _____

WHO MAY WE SHARE YOUR MEDICAL INFORMATION WITH?

____ SPOUSE (NAME): _____

CELL PHONE: _____

WORK PHONE: _____

____ PARTNER/SIGNIFICANT OTHER (NAME): _____

CELL PHONE: _____

WORK PHONE: _____

____ PARENT (NAME): _____

CELL PHONE: _____

WORK PHONE: _____

____ OTHER: _____

RELATIONSHIP: _____

CELL PHONE: _____

WORK PHONE: _____

Patient's Name: _____

Signature: _____