

AUTHORIZATION TO COMMUNICATE WITH A TRUSTED INDIVIDUAL

PATIENT INFORMATION

Patient full name

Date of birth (YYYY-MM-DD)

AUTHORIZED INDIVIDUAL

Full name

Relationship to patient

Phone number

Email address

MY AUTHORIZATION

I authorize Wellbird Health, including its physicians and staff, to communicate with the person named above about my personal health information and care.

This authorization includes:

- booking, cancelling, and rescheduling appointments;
- discussing referrals, investigations, prescriptions, diagnoses, treatment plans, follow-up, and other health-related matters; and
- providing copies of my records, reports, results, or correspondence when requested and permitted by law.

Important: This permission applies to information created before and after I sign this form. It does not allow the authorized person to consent to treatment or make health-care decisions for me unless that person has separate legal authority.

HOW LONG THIS AUTHORIZATION LASTS

Choose one:

- ☐ It remains in effect until I cancel it or sign a newer authorization.
☐ It expires on: _____ (YYYY-MM-DD)

I may change or cancel this authorization at any time by notifying Wellbird Health in writing. This will not affect information already shared before the clinic received my notice. I am responsible for telling Wellbird Health promptly if my wishes or relationship with the authorized person change.

SIGNATURE

I have read and understood this form. I am signing voluntarily.

Patient name

Patient signature

Date
