ALZHEIMER'S MEMORY CENTER

Permission to Communicate with Caregivers/Family

I _____ give consent to Alzheimer's Memory Center to share health information with the people listed below who assist with my care. I understand that this authorizes Alzheimer's Memory Center to share certain health information. If I do not want to share certain information, I have listed it below.

Do not release information about: _____

Name	Phone Number	Relationship

_____

_____

Patient/Patient Representative Signature Date Print Name

Date of Birth: _____

Witness: _____ Date: _____