Cheryl Newman M.D.
Family Medicine

Share Information

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Name:_____

I give the office of Cheryl A. Newman M.D. permission to communicate with the following people about my medical care:

Including: (please check all that apply)

[ ] All medical care
- [ ] Making and rescheduling appointments
- [ ] Diagnosis information
- [ ] Medication requests
- [ ] Plan of care

Name (please print) Relationship

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I understand this will remain in effect until I state otherwise, and that I can rescind this authorization at anytime.

_____ _____
Signature (or signature of guardian if minor) Date