

GLENDALE AREA MEDICAL CENTER
850 Main Street
PO Box 375
Coalport, PA 16627
(814) 672-5141

Date: _____

I, _____, give permission to the Glendale Area
Medical Center providers to discuss my medical condition and care with:

Any Exceptions (disease processes, diagnostics/labs, persons, etc.):

It is your responsibility to notify us of any changes, as they occur.

Signature _____

Date _____

This authorization will automatically expire in one-year, unless otherwise stated:

Witness _____

Reviewed and Dated:

