To: Shalvata Mental Health Center

Medical Waiver Confidentiality

A. Personal details

ID number	First name	Last name
phone	Full address	

I The undersigned, herby grant permission to **Shalvata Mental Health Center** and/or to its employees, and/or any person acting on its behalf to submit to **(Name)**: _____
ID number: _____
All and/or any information ans details in any way requsted by him pertaining to my state of health, and/or to any sickness or mental health I had in the past, and/or have in the present and/or will have in the future.
I hereby relinquish my right to confidentiality to you, and/or to your employees, and/or whoever will act on your behalf in matters concerning my state of health and/or sickness, and shall have no claim of any kind in this regard.

This waiver will be valid until _____ (Date)

Patient signature
(If the patient is a minor or under legal gurdianship, make sure it is signed by the legal guardian)

Date_____ full name: _____ ID number _____

Signature_____

B. witness to signature (doctor, nurse, lawyer, professions Health Licensed)

ID number	First name	Last name
License number	Duty	phone

signature _____

stamp signature _____

_____ Date