

Consent to Discuss Health Care

Patient

Name: _____

Today's Date: _____

Date of Birth: _____

I authorize _____

To discuss my health care information with the individuals listed below. (Please print clearly).

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

Name: _____ Relationship _____

I give permission to leave my health care information at the following telephone number(s). Please print).

Number: _____ Home: _____

Number: _____ Cellular: _____

Number: _____ Work: _____

Signature of Patient, Parent or Legal Guardian: _____