CONSENT TO DISCUSS MEDICAL INFORMATION

PATIENT INFORMATION

PATIENT NAME: _____ DOB: _____

PHONE NUMBER: _____ _____

NAME: _____

PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

NAME: _____

PHONE NUMBER: _____

RELATIONSHIP TO PATIENT: _____

MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR ANSWERING MACHINE AT HOME?

( ) YES ( ) NO

MAY WE MAIL OR EMAIL PERSONAL MEDICAL INFORMATION TO YOU?

( ) YES ( ) NO

EMAIL ADDRESS:_____

ADDRESS:_____

PATIENT/GUARDIAN SIGNATURE:_____