Please list the names of the person or persons to whom we can discuss medical information with.

_____ _____

_____ _____

Do you consent to a medical exam and any procedures or test deemed necessary by our doctor while you are in the office? YES NO

Do you wish for our office to release medical information to any specialists that we refer you to? YES NO

Do you consent to the staff releasing information about appointments and/or test results to someone on your list? YES NO

I have read, understand, and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of information for insurance filing and pre-certification by signing this statement.

Printed Name:_____

Signature:_____ Date:_____

Please lest the pharmacy that you wish to keep on file for your prescription refills.

Local Pharmacy Name:_____ Phone#_____

Mail Order Pharmacy Name:_____ Phone#_____