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## CONSENT TO RELEASE

This form allows you to decide who you would like for the physicians or their representative to speak with about your medical care in this office. This includes but is not limited to laboratory results, test results, treatment options, and billing information. **We will not be allowed to speak with anyone that is not listed on this form including parents, spouses, and children.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

\_\_\_\_\_ I DO NOT want my information discussed with anyone other than myself. I understand that my provider will not be able to speak with my spouse, child(red), or parents.

\_\_\_\_\_ I give permission for the providers and their representatives to discuss my medical care as outlined above with the following people:

Name	Relationship	Telephone
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I understand that I can change this decision in writing at any time.

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Patient or Guardian Signature

Date