PATIENT AUTHORIZATION FORM

_____

Patient Name

_____/_____/_____

Patient's Date of Birth

The section below is to give Diabetes & Endocrine Associates my permission to contact and discuss my health care with the following people.

_____ (_____)_____

Name Phone Number

_____

Relationship to patient

_____ (_____)_____

Name Phone Number

_____

Relationship to patient

Specific information that should / should not be disclosed is:

Circle One

_____

_____

_____

Please check which method Diabetes & Endocrine may contact you:

☐ **Home** ☐ **Cell Phone** ☐ **Work Phone**

☐ **Leave a message – Appointment day & time – Physician name & number**
☐ **Do not leave a message of any kind**

_____ _____/_____/_____

Patient Signature **Date**

_____ _____ _____/_____/_____

Signature of Guardian, **Description of Authority** **Date**

Revised 06-2016