Permission for
Verbal Communications

Tricity Family Medicine
& Urgent Care Clinic
107 Hyannis Dr
Holly Springs, NC 27540

___________________________ ___________________________

(Patient Name) (Date of Birth)

I permit Tricity Family Medicine to discuss my health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members or friends & state relationship)

1.____

(Name) (Phone number) (Relationship)

2.____

(Name) (Phone number) (Relationship)

3.____

(Name) (Phone number) (Relationship)

____ ***Check here <u>ONLY</u> if you <u>DO NOT</u> want <u>ANY</u> health or billing information to be discussed with anyone other than yourself!!***

If, at any time, I do not want verbal discussions to be permitted between my Health Care Provider and any of the individuals named above, I must notify my Health Care Provider.

Patients signature:________________________________ **Date:**________________________________

Dr. Chaitany Patel, MD