EVERGREEN
FAMILY HEALTH GROUP

PERMISSION TO DISCUSS MEDICAL CARE
THIS ALLOWS US TO SPEAK WITH SOMEONE ELSE REGARDING YOUR CARE AND/OR PAYMENT FOR YOUR CARE i.e., FAMILY, FRIENDS, OR OTHERS

Today's Date: _____

I_____ give my permission to **EVERGREEN FAMILY HEALTH**
(print your name)

to discuss my medical care with:_____
(print name or names)

Relationship to patient:_____

I understand that I have the right to revoke my permission at any time except where Evergreen Family Health has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

Patient Signature: _____ DOB:_____

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