Permission to Discuss Form

Patient Name: _______________________________________ DOB: ___/___/___

Permission to Discuss

I, the undersigned, give Thundermist Health Center permission to discuss my medical and dental information with:

Name #1: ____________________________________ Relationship: ___________________________

Home Phone: ________________ Cell Phone: _________________ Work Phone: _______________

Name #2: ____________________________________ Relationship: ___________________________

Home Phone: ________________ Cell Phone: __________________ Work Phone: ______________

I understand I can revoke this authorization at any time through a written or verbal statement to Thundermist. I understand if revoked, it will apply to all individuals on this form.

Patient/Legal Guardian Signature: ____

Date: _____ / _____ / _____

R&C 04/2023