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PATIENT'S NAME _____

Due to Federal Guidelines (HIPAA), we will no longer be able to speak to any person on your behalf without your signed consent. Please indicate below, by name, if there is a family member, friend or physician with whom you would like us to share your medical information via telephone, mail, fax, or in person.

RELATIONSHIP	NAME
Primary Care Physician	_____
Other Physician	_____
Mother	_____
Father	_____
Spouse	_____
Child	_____
Friend	_____
Other	_____

SIGNATURE

DATE