



PERMISSION TO VERBALLY DISCUSS PROTECTED INFO

Today's date: _____

Constance George-Adebayo, MD

PATIENT INFORMATION

Patient's last name:	First:	Middle: I	<input type="checkbox"/> Mr.	<input type="checkbox"/> Miss	Marital status (circle one)	
			<input type="checkbox"/> Mrs.	<input type="checkbox"/> Ms.	Single / Mar / Div / Sep / Widow	
Address 1		DOB	Age		Contact phone :	
Address 2						
Email:		City:	State:		ZIP Code:	

I give permission to Christ the King Medical Center to VERBALLY to discuss the following medical and billing information about me:

- Appointment Information
- Medical Information- including my symptoms, diagnosis, medications and treatment plans.
- Behavioral Health information
- Hospital
- Lab/Test Results
- Billing and payment information
- Other (describe)

Christ the King Medical Center has my permission to discuss the above information with:

Name 1:		
Street Address:		
City:	State:	Zip Code:
Phone:		
Name 2:		
Street Address:		
City:	State:	Zip Code:
Phone:		

I understand that I have the right to revoke my permission at any time except where Christ the King has already made disclosures in reliance upon this request. I understand that I must notify Christ the King Medical Center in writing if I want to revoke my permission.

Patient Signature _____ Date _____

Guardian signature _____ Date _____