Permission to Discuss Form

Patient Name: ____DOB: ___/___/___

Permission to Discuss

I, the undersigned, give Thundermist Health Center permission to discuss my health information with:

Choose selection (select all applicable) ◯ Medical ◯ Dental ◯ Behavioral Health

Name #1: _________________________________ Relationship: ________________________

Home Phone: _______________ Cell Phone: ________________ Work Phone: ______________

Name #2: _________________________________ Relationship: ________________________

Home Phone: _______________ Cell Phone: _________________ Work Phone: _____________

Choose selection (select all applicable) ◯ Medical ◯ Dental ◯ Behavioral Health

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: ____

Patient/Legal Guardian Print Name:____

Date: _____ / _____ / _____