

AUTHORIZATION TO DISCUSS PATIENT MEDICAL INFORMATION

Date: _____

To Whom It May Concern:

I, _____, give permission to Dr.
Print your name

Powell and her staff to discuss (*give specific parameters*):

with _____, _____
Name of person(s) *Relationship*

from _____ until _____
Date *Date*

Signature _____ *Date* _____

Witness _____ *Date* _____

Witness _____ *Date* _____