

**Permission to Speak to Another  
Individual Regarding Medical Care**

Patient Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Names of people you would like us to speak with on your behalf with regards to your medical care:

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Date