Permission to Discuss Protected Health Information with Family and Friends

I give permission for the Metropolitan Neurosurgery P.A to share my information with the family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of my health care.

This includes, verbal discussion, scheduling/appointment information, labs, imaging reports, billing records, etc)

Name:
_____

Relationship:
_____

Phone Number:
_____

Name:
_____

Relationship:
_____

Phone Number:
_____

Name:
_____

Relationship:
_____

Phone Number:
_____

Name:
_____

Relationship:
_____

Phone Number:
_____

☐ **I do not wish to list any individuals.**

This consent does not expire until I revoke it and I understand that I must do so in writing. I understand that I have the right to revoke my consent at any time and that my revocation shall have no effect on any actions taken prior to my revocation.

Signature: _____ **Date:** _____