Nissi Family Medicine
- Caring is our Passion -

PERMISSION TO SPEAK TO FAMILY MEMBERS

In certain situations, we may need to talk to family members about your medical/billing information, but before we can do that we need your consent.

PLEASE MAKE A SELECTION BELOW

_____ I, _____ decline release of my medical/billing information to anyone.

_____ I, _____ give permission for Nissi Family Medicine physician(s) and/or staff to release or discuss lab results or any other information including but not limited to information in my medical/billing record with the following person(s).

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

This information release shall be in effect until revoked by me in writing.

_____ _____ _____
Patient's Signature Date of Birth Date

_____ _____
Patient's Printed Name Account Number

_____ _____
Witness Date