GASTROINTESTINAL MEDICINE ASSOCIATES, INC.
www.GIMEDRI.com

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PERMISSION TO DISCUSS MEDICAL CARE

DATE:_____

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

I,_____, will allow the physicians and staff at Gastrointestinal Medicine Associates, Inc. to discuss any and all issues concerning my medical care with _____
_____
_____
_____
_____
_____
RELATIONSHIP TO PATIENT:_____

NOTE: Unless Gastrointestinal Medicine Associates, Inc. is notified by you in person or by certified mail, the above PERMISSION TO DISCUSS MEDICAL CARE shall remain in effect indefinitely.

When it is necessary to contact you by telephone, i.e. to confirm or cancel an appointment, to give information to you regarding a booking or test that our office has scheduled on your behalf etc., may we call the telephone numbers which you have provided, and if you are not available may we:

_____ leave a message on your answering machine
_____ leave a message with anyone other than yourself
_____ Name of Person or Persons_____
_____
_____ Anyone who answers

Telephone numbers we may call:
_____home
_____work
_____other

Signed:_____
Date:_____ witness:_____