CONSENT TO DISCUSS MEDICAL CARE
(with family or friends)

Patient Name: _____

(First, Middle Initial, Last)

Date of Birth: _____

I authorize Hughes Physical Therapy to discuss my medical and/or appointment information with the following individuals I have listed below. (Please print all names)

NAME: _____ PHONE #: _____
RELATIONSHIP: _____

NAME: _____ PHONE #: _____
RELATIONSHIP:_____

NAME: _____ PHONE #: _____
RELATIONSHIP:_____

I give my permission for Hughes Physical Therapy to leave medical and/or appointment information at the telephone number(s) that I have provided on the patient intake forms.

_____ _____
Signature of Patient, Parent, or Legal Guardian Date Signed

_____
Printed name of signature above