Casalim Family Medicine
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Patient Confidentiality / Permission Form

(please sign either the Top -or- Bottom portion of this form.)

If your are giving permission to anyone other than yourself to discuss your medical care, please read this information carefully and sign the top portion.

I, _____ give permission to the person(s) listed below to receive information on my behalf pertaining to my care. This permission will extend to making and verifying appointments, billing information, discussing laboratory results, and my general care with office staff and/or physicians.

Representative Names:

1. _____

2. _____

3. _____

_____ _____

Patient Signature *Date*

If you do NOT give permission to anyone to discuss or receive information on your behalf, please sign the statement below:

I, _____ do not give permission for any of my medical care to be discussed with anyone other than myself.

_____ _____

Patient Signature *Date*