



# Bent Tree Family Physicians

## Authorization to Discuss Medical Information

Bent Tree Family Physicians is committed to quality patient care and maintaining patient confidentiality. Our policy is to communicate only to patients and/or guardians personally or through our patient portal in regards to their confidential medical information. By completing the information below, you are allowing Bent Tree Family Physicians to communicate more detailed information to other individuals and/or your voicemail.

Patient Name:	Date of Birth:	Preferred Phone Number:
Preferred Email Address:		

### Phone Messages:

I give permission to Bent Tree Family Physicians to leave a detailed voicemail message regarding my medical care for me at the *Preferred Phone Number* listed above.

I do not give permission to Bent Tree Family Physicians to leave a detailed voicemail message regarding my medical care for me at the *Preferred Phone Number* listed above.

### Person-to-Person Communication:

I give permission to Bent Tree Family Physicians to verbally discuss information about my medical care with the following individual(s): (*optional*)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

**Please share:**     Scheduling Information         Medical Information     Billing Information

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

**Please share:**     Scheduling Information         Medical Information     Billing Information

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Best Contact Number: \_\_\_\_\_

**Please share:**     Scheduling Information         Medical Information     Billing Information

**I understand that this consent will remain effective until I notify Bent Tree Family Physicians in writing.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_