Patient Name_____

AUTHORIZATION FOR PEOPLE INVOLVED IN PATIENT'S CARE

I have the right to choose family members, friends or others to be involved in talks about my health care. The people listed below may receive any verbal information needed to be involved in my care or to help me make decisions about my care. By signing this form, I give my permission to a staff member within the office of Dr. Jonathan Eagle, to discuss information about me with the people listed. The information discussed may include diagnosis, test results, medicine, treatment options and other information from previous services I have had in other offices.

- I know that information may be discussed with family members or others without this form, if allowed by federal and state laws.
- I know that listing a person on this form does not allow them to get or copy my medical records.
- People listed on this form are not allowed to give consent for services for me.

List people that may receive verbal information about your care and pick up prescriptions

Name of Person	Relationship	Contact Phone #	Allowed to receive verbal information about your care	Allowed to pick up all prescriptions
			☐	☐
			☐	☐
			☐	☐

☐I do NOT wish to name anyone (initial) _____

I can update this form at any time by telling a staff member within the office of Dr Jonathan Eagle AND by filling out a new form. I can take away my permission to share my information at any time by putting that request in writing and giving that request to a staff member within the office of Dr. Jonathan Eagle. Any information that may have been released prior to the authorization being changed and or updated cannot be taken back by the office.

PATIENT SIGNATURE(S)

I have read this form and I understand it and all my questions have been answered.

TIME_____ **DATE**_____ **PATIENT SIGNATURE**_____

_____**Patient is under 18 years of age or otherwise unable to consent because:**

_____

Parent/Legal Guardian/Patient Advocate/Next of Kin Signature_____

(Shared/consult/authorization)