

# NEUROLOGICAL CONSULTANTS, P.C.

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To protect your privacy, please list below all the people whom you give Neurological Consultants, P.C. permission to discuss and/or release your medical information to (i.e. spouse, family members, etc.) Further understand this may include mailed reports, faxes and/or telephone communications.

Name of Person	Relationship to patient
_____	_____
_____	_____
_____	_____
_____	_____

If you wish to delete someone off this list, you must do so in writing.

Patient Printed Name \_\_\_\_\_

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

If signing as a personal representative off the patient, describe the relationship to the patient and the source of authority to sign this form:

\_\_\_\_\_ Relationship to patient \_\_\_\_\_ Print Name

Source of Authority \_\_\_\_\_