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, emails, and/or telephone communications.

Name: __________________________ Phone: (     ) _______-
Relationship to patient: ______________ Does this person live with you Y / N

Name: __________________________ Phone: (     ) _______-
Relationship to patient: ______________ Does this person live with you Y / N

Name: __________________________ Phone: (     ) _______-
Relationship to patient: ______________ Does this person live with you Y / N

Name: __________________________ Phone: (     ) _______-
Relationship to patient: ______________ Does this person live with you Y / N

Name: __________________________ Phone: (     ) _______-
Relationship to patient: ______________ Does this person live with you Y / N

**If you wish to delete someone from the above list, you must do so in writing.

Patient Printed Name__________________________________
Patient Signature     ___________________________________Date_________

If signing as a personal representative of 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______________________________________________________________