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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, 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_____