Pacific Frontier Medical, Inc.
Consent to Speak to Others About Care

Date:_____

Patient Name:_____

DOB:_____

I, _____ grant authorization for Pacific Frontier Medical, Inc. including all providers and staff to discuss, leave confidential medical information, and/or talk about my care and treatments as specifically follows:

_____ All Medical information

_____ Only selected information:

- Appointments dates and times
- Questions and answers regarding medical care
- Lab results
- Other _____

With the following people only:

1) _____ Relationship:_____

2) _____ Relationship:_____

3) _____ Relationship:_____

By signing, the patient or legal guardian is confirming that the above reflects their request of how our office may communicate medical information with this patient.

Patient Signature:_____Date:_____

Guardian Signature (if applies):_____Date:_____