PERMISSION TO GIVE MEDICAL INFORMATION

I_____ hereby authorizes the physician and staff of Diagnostic Partners of North Texas, P.A. to contact the following people concerning my health and well being, **in case of an emergency**:

Name: _____ Tele#:_____ Relationship: _____

How would you like to be contacted regarding appointments, test /lab results, medications, procedures and any other information regarding your health or payment for your healthcare provided at Diagnostic Partners of North Texas, P.A.?

Home Telephone: _____ Cell Phone: _____

Work Telephone: _____

Other: _____

If you have an answering machine, may we leave message regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Diagnostic Partners of N. TX, P.A.?

_____ YES _____ NO _____ N/A

If "NO", how else may we contact you regarding this information? In order to get your results via the mail, we require you to provide self addressed, self stamped envelope.

_____

I understand I may revoke this consent at any time by giving written notice to the person or organization making the disclosure.

Signed: _____ Date: _____