PERMISSION TO GIVE MEDICAL INFORMATION & EMERGENCY CONTACT

I,_____hereby authorize the physicians and staff of Texoma Arthritis Clinic, P.A. to give the following people information about my health and well being.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

The following information may be given:

	People listed above	Answering Machine
Appointment Time	yes or no	yes or no
Test/Lab Results	yes or no	yes or no
Medications	yes or no	yes or no
Procedures	yes or no	yes or no
Any info. not listed above regarding my health	yes or no	yes or no

In case of an Emergency you may contact:

Name:_____ Phone:_____ Relationship_____

Name:_____ Phone:_____ Relationship_____

Preferred Pharmacy: _____ Phone: _____

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

Signed:_____ Date:_____
(Patient/Paretn/Legal Guardian)

Witness:_____ Date:_____