PERMISSION FOR DISCUSSION OF MEDICAL INFORMATION

Name _____ Birth Date _____

I permit Craven Physical Therapy & Spine , their therapists and other personnel to discuss, either verbally or written, my health information, in person or by telephone, with the following family members or friends involved in my medical care:

	Name	Phone Number	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

If, at any time, I do not want discussions to be permitted between Craven Physical Therapy & Spine (CPT&S) and any of the individuals named above, I must notify CPT&S in writing.

Patients Signature _____ Date _____