



Permission to Discuss Health Information With Family, Friend(s) and/or Care Provider(s)

PATIENT NAME _____ DOB _____

The above named patient gives permission for Northland Plastic Surgery to discuss any medical care with those individuals identified below:

Name (Please Print)	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Primary Spokesperson (if desired) _____

This permission is for:

- _____ This visit/procedure only.
- _____ This visit/procedure and all future visits/procedures.
- _____ Any past, present or future medical care.

Date _____
Signature of Patient or Guardian Granting Permission

Date _____ Verbal consent taken by _____