1123 Heatherstone Drive • Fredericksburg, VA 22407

Authorization to Communicate with Persons for Adult Patients

I, ________________________________, hereby give my consent for the following named adults to discuss certain aspects of my medical care and record, as dictated, with the medical facility physicians, staff members, and other associates within the medical facility.

Name: ___________________________ Phone: ___________________ Relationship: ______________

All Information ☐ Appointment Date/Times ☐ Diagnosis ☐ X-ray Results ☐
Medications ☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan ☐
Other (specify): ☐ ____

Name: ___________________________ Phone: ___________________ Relationship: ______________

All Information ☐ Appointment Date/Times Diagnosis X-ray Results
Medications ☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan ☐
Other (specify): ☐ ____

Name: ___________________________ Phone: ___________________ Relationship: ______________

All Information ☐ Appointment Date/Times Diagnosis X-ray Results
Medications ☐ Lab Tests/Results ☐ Summary of Medical Record ☐ Care Plan ☐
Other (specify): ☐ ____

May we leave detailed information, appointment information and/or test results on your personal answering machine? (circle one): Yes No

Specific Instructions or Limitations, if any:

We will continue to rely on the information of this form when communicating with family members or others involved in your care unless you request changes in writing. Please notify this office promptly if you wish to alter the designations noted above.

Printed Name of Patient: ____

Signature of Patient: ____________________________ Date: ___________