Mountain View Gastroenterology, PC

Patient Confidentiality Permission Slip

If you are giving permission for anyone other than yourself to discuss your medical care, please read this information carefully and sign where indicated.

I,________________________________ give permission for my family member, spouse/partner, friend listed to receive information on my behalf pertaining to my medical care. This will extend to making and verifying appointments, billing information, discussing laboratory results and discussing my general care with either office staff and/or physician.

(please list authorized names here):

____

____

Your Signature: ____________________________________Dated: _______/_______/______

Witness: ____ Dated: _______/_______/______

If you **do not give permission** for anyone to discuss or receive information on your behalf, please sign statement below:

I, ______________________________**do not give my permission** for any of my medical care to be discussed with anyone other then myself.

Your Signature: ____________________________________Dated: _______/_______/______

Witness: ____ Dated: _______/_______/______