PediatricSpecialists OF TULSA

CONSENT FOR FAMILY MEMBER OR DESIGNEE ACCESS TO MEDICAL AND BILLING INFORMATION

Patient Name: _____ DOB: _____

Patient Phone: _____

The family member or friend listed below assists in my care.

I, the above-named patient, have no objection and hereby consent to [list family or designee name(s)]

_____

_____

Receiving and having access to my medical records, and/or discussing such information with my healthcare providers or the billing office.

Permission is granted to the Physician or Physician's staff to leave medical appointment or information messages on my answering machine.

☐ Yes ☐ No

This consent shall remain in effect until further notice.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date