



PERMISSION TO DISCUSS MY HEALTHCARE WITH FAMILY MEMBERS AND FRIENDS

Patient Name: _____ Patient Date of Birth: ____/____/____
(Please print)

I allow Gragil Associates, Inc. to discuss my health care with the individual(s) named below. These individuals play some role in my care, either by assisting me directly or by offering support to me and other family members. I understand that this form does NOT give the individuals named below any authority to make health care decisions for me. It also does NOT allow them to access my medical record. This document is not a health care power of attorney. The sole purpose of this form is to protect my privacy by ensuring that my health care will be discussed only with individuals I have chosen.

Printed Name of Individual Relationship Phone Number
Authorized to Receive Information

Printed Name of Individual Relationship Phone Number
Authorized to Receive Information

Please Note: This authorization will expire 12 months from the date this form is signed. If I wish to continue this authorization after that date, a new form must be completed.

Printed Name of Patient or Legal Representative/Guardian Date

Signature of Patient or Legal Representative/Guardian

Form can be emailed, mailed or FAXED to: Gragil Associates, Inc. P.O. Box 1010 Pembroke, MA 02359 FAX: 781-826-6367 collections@gragil.com

Revocation of Permission to Discuss my Health care with Family Members and Friends

I revoke all privileges of one or both of the following individual(s) _____ effective: (Date) ____/____/____

Patient Signature: _____

I understand that Gragil Associates, Inc. cannot take back any information that it shared when it had my permission to do so.