THE WASHINGTON ENDOCRINE CLINIC PLLC

Medical Treatment Authorization

I permit the medical providers and/or staff of The Washington Endocrine Clinic ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care.

(List family members/friends and state the person's relationship to the patient).

Name	Phone Number	Relationship
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

This authorization is limited to verbal discussions regarding the following medical condition(s):
_____
(If no limitations are listed, verbal discussions will be permitted regarding any medical condition for which the patient has received care.)

Release of medical information under this document is limited to verbal discussions only. This document does NOT permit release of any written medical records to the individuals named above. For a release of medical documents and notes, the patient must fill out the "medical records release form" found on the Clinic's web site.

This authorization is limited to the following time frame:
Starting from _____ (date) to _____ (date).
(If no dates are indicated, this form will remain in effect for an unlimited amount of time.)

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify the medical providers and/or staff by contacting the Washington Endocrine Clinic and asking for this form to be deleted from my medical file.

Patient Signature: _____ Date: _____

Patient Name (print): _____ Date of Birth: _____
(For patient protection a real signature is required-- please do not just type your name).

2440 M Street, NW • Suite 417 • Washington, D.C. 20037
Phone 202-570-5151 • Fax 202-446-2946

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If this Release is signed by a representative on behalf of the patient, complete the following:
Representative Name:_____
Relationship to Patient: _____
Representative Signature:_____

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