NORTH BUNCOMBE FAMILY MEDICINE, PA

Permission to Release Information to Other Individuals

In order to release any verbal information about you to other individuals including your family members, friends and/or individuals involved in your care, we must obtain permission from you. The following is an authorization for North Buncombe Family Medicine, P.A. to release verbal information to an individual that you authorize. Release of your information will be restricted to these individuals only unless additional authorization is provided.

This authorization does ***not*** apply to other physicians including your referring physician. Disclosures for treatment purposes are authorized by consent for treatment.

I authorize the following individuals to obtain verbal information regarding my medical condition, medicines, appointments, and/or billing information at any time:

Name	Relationship (spouse, son, daughter, friend, caregiver, etc.)
_____	_____
_____	_____
_____	_____
_____	_____

Print Patient's Name: _____

Patient's Signature: _____

Date of Birth: _____

Social Security #: _____

Date: _____

Witnessed By: _____