REGENCY HEALING MEDICAL CLINIC

Healing And Preserving Our Community

Consent to discuss Medical Information with Third Party

I hereby authorize Regency Healing Medical Clinic

To discuss all Medical Treatment and Plan with authorized Person:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____/_____/_____

Name of Individual: _____

Relationship: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____