WAYLAND PERSONAL PHYSICIANS
Medical Excellence. Individualized Care.

<u>CONSENT TO DISCUSS MEDICAL INFORMATION</u>

I ______________________
Name
____
Address
______________________,

consent to Wayland Personal Physicians the permission to discuss my medical information to the listed party/parties below. At my request this document will become null and void.

Name____________________________
Address__________________________
____
Phone___________________________

Name____________________________
Address__________________________
____
Phone___________________________

With the exception of (*please list any medical conditions you decline from being disclosed*):

____
____
____
____

____
Name

____
Date of Birth

____
Signature

____
Date