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Consent to Speak

I ______________________________
(enter patient name here)
authorize Orlando Diabetes and Endocrine Specialists to speak to the following named individuals on my behalf. I may rescind this permission, in writing, at any time.

Name: ____________________	DOB__________	Relationship ____________________
Name: ____________________	DOB__________	Relationship ____________________
Name: ____________________	DOB__________	Relationship ____________________

Situations that may be discussed with the following individuals named are as follows

Please Answer **Yes or No**

- Appointment Scheduling ______
- Appointment Canceling ______
- Appointment Rescheduling ______
- Notification of Insurance changes _____
- Medication Refills ______
- Billing Questions ______
- Bill Payment ______
- Test Results ______

Patient Name: ________________________________ SS#: ____________________________

Address: ____ DOB: ________________

Signature: ________________________________ Date: ____________

____
Witness Name Signature Date