MedStar Montgomery
Medical Center

Patient Name: _____ (Printed)

D.O.B: _____

This is to notify the Department of Breast Health & Imaging at MedStar Montgomery Medical Center that I grant permission for Doctors, Nurses and other staff members of this department, to communicate freely about my medical condition with family members or friends either in person, on the telephone, or in writing. This applies to the following individual(s):

Name & D.O.B.	**Relationship**	**Phone #**
_____	_____	_____
_____	_____	_____
_____	_____	_____

I also grant permission for messages to be left for me on the phone number(s)below regarding the following:

Appointments _____ Test Results _____ Prescriptions _____

Cell _____ Home _____ Work _____

Unless otherwise indicated, this permission will expire one (1) year from the date below.

Signature _____ Date _____