



Clarks Summit • Tunkhannock
570-587-3277

PERMISSION FOR VERBAL COMMUNICATION WITH FAMILY AND FRIENDS

(Patient Name)

(Date of Birth)

(Street address) (City, state, zip code)

(Phone number)

I permit Abington Audiology and Balance Center, their Audiologists and other personnel to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient).

Name/ Phone Number/ Relationship

1. _____
2. _____
3. _____

If, at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting Abington Audiology and Balance Center at 570-587-3277.

Patient's Signature: _____ Date: _____