Parkview Medical Clinic
1400 1st St NE
New Prague MN 56071
PH: 952-758-2535
FAX: 952-758-6101

Authorization by Patient to Speak to Other Individuals

This form should be completed by the patient if the patient allows Parkview Medical Clinic staff to speak with someone other than the patient about their care.

Patient Name: _____ **DOB: _____**

MRN: _____

I authorize the staff and Parkview Medical Clinic, including but not limited to physicians and nurses, to speak with the following individual/s at any time regarding my medical care at Parkview Medical Clinic.

I understand that I may revoke this authorization in writing at any time in the future and that I need to notify Parkview Medical Clinic of any changes.

Individuals Parkview Medical Clinic can speak to about my care:

First and Last Name	Relationship to Me	Phone #

_____ _____

Patient Signature **Date**