

Charleston Internal Medicine, Inc.

3701 MacCorkle Avenue, SE

Charleston, WV 25304

(304) 720-2345

Patient's Name: _____ Date of Birth: _____

Please list below those individuals you give us permission to discuss your medical care with. These individuals will also be able to pick up written prescriptions and testing results in our office on your behalf. If someone calls or comes to our office and requests health information, including, but not limited to testing results, and prescriptions for you, and they are not listed below, we will not be able to assist them. You can update your list at anytime.

<u>Name</u>	<u>Relationship</u>	<u>Contact Number</u>
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1.

2.

3.

4.

5.

6.

Patient's Signature

Date