

**Dr. Rajiv. R. Patel, BDS, MDS**  
120 E. New York Ave., Suite E  
Deland, FL 32724  
(386) 738-2006

## AUTHORIZATION TO DISCUSS HEALTHCARE ISSUES

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Date of Birth

I hereby authorize **Dr. R. R. Patel** and/or his other staff members to discuss my healthcare issues with the following person(s):

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

I understand I have the right to:

- Receive a copy of this authorization
- Revoke this authorization

This authorization will remain in effect until the following date: \_\_\_\_\_ or  
until otherwise notified (initial here): \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient/Legal Representative

\_\_\_\_\_  
Date

Relationship to Patient \_\_\_\_\_