

GROBY SURGERY

FORM OF AUTHORITY



PATIENT'S NAME: _____

ADDRESS: _____

DATE OF BIRTH: _____

I fully consent to the person(s) named below discussing my care and medical information on my behalf, including results and prescriptions.

	NAME OF NOMINEE	RELATIONSHIP TO PATIENT	CONTACT NUMBER(S)
1.			
2.			
3.			
4.			

PATIENT SIGNATURE: _____

NOMINEE/S SIGNATURE :

1 _____ 2 _____

3 _____ 4 _____

DATE: _____