



Patient Identification:						
Name				Date of Birth		
	Communication with Fan	nily and Others Involved	d In Your Care			
Please list any family members or other		oordinating your care or pay ared with each individual.	yment for care.	Also, indicate wh	iat kind of i	information
NAME		RELATIONSHIP TO PATIENT	ALL	Scheduling/ Appointments	Medical	Billing/ Insurance
			<u></u>			
<u> </u>					[
		Principle of the Control of the Cont	 -			
	***************************************		L			
					r r	
Specific Instructions or Limitations:			others involved in	your care unless γκ	ou request c	hanges. Please
Signature of Patient or Legal Guardian:		apove.				
_	Time:		ionship to Patient	;		
To revoke this	is authorization, please se	end a written request to	o the address n	ioted above.		
	Ifyou have any que	estions, please call (270) 688-:	1500			