

**GHENT FAMILY PRACTICE, INC.**  
**3535 Granger Road**  
**Akron, OH 44333**  
**330-666-3400**  
**www.ghentfamilypractice.com**

**AUTHORIZATION TO DISCUSS MEDICAL CARE  
WITH FAMILY MEMBERS AND/OR OTHER INDIVIDUALS**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I hereby authorize the physicians and staff of Ghent Family Practice to discuss the medical care of the patient named above with the people listed below. This may include, but is not limited to, releasing information related to psychiatric care, drug use, alcohol abuse, HIV testing, ARC and AIDS.

I understand that this consent is revocable upon written notice, except to the extent that action has been taken in reliance on this authorization, and that this authorization shall remain in force for 5 years unless revoked.

NAME:	RELATIONSHIP:	PHONE:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature of Patient, Parent or Legal Guardian:  
\_\_\_\_\_

Date of Authorization:  
\_\_\_\_\_

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