HAGANhealth
HEALTHY MIND. HEALTHY BODY. HEALTHY CHOICES

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Permission To Share Information

I give permission to, Terry M. Hagan, M.D. to discuss in general terms my diagnosis and treatment with the following people:

Therapist (permission to communicate with your therapist regarding your treatment)

Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Family Physician (permission to communicate with physician regarding your treatment)

Name: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Family Member(s) (permission to communicate with the following family member(s)

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Other (special requests, such as medical records be sent to someone other than PCP)

Specific Request: _____

To:_____

Address:_____

Phone: _____Fax: _____

Patient's Signature: _____

Witness: _____ Date: _____