EFPMC
East Florida Premium Medical Care

I,_____, freely give my permission for the health care providers at East Florida Premium Medical Care, LLC to discuss any and all issues pertaining to my health with the following individuals **(please do not list doctor's, RELATIVES ONLY)**

_____ _____

_____ _____

This consent is given with full understanding that any information will be given verbally only. Physical copies of medical records must be requested and collected by me. Consent is also given with full understanding that I may change, remove, or add names to the list, or withdraw consent altogether, at any time.

Exception: Please circle may or may not below.

The following issues specific to my health **MAY/OR MAY NOT** be discussed.

- Issues related to Sexually transmitted diseases
- Issues related to Pregnancy
- Issues related to psychiatric diagnoses
- Other issues (please list):

  _____

  _____

_____ _____

Patient Signature Date

East Florida Premium Medical Care

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