The Joint and Spine Pain Center

John L. Stanton, MD
Medical Director

351 Dover Road, Suite B
Clarksville, TN 37042
p: 931-919-3813
f: 931-919-4279
www.paincenterclarksville.com

Jens K. Palmer, ANP-C

MEDICAL CONSENT FORM

This form authorizes the stated person(s) to inquire or receive the information listed.

NAME OF PATIENT: _____

DATE OF BIRTH: _____

(Patient/Parent/Guardian)

I, _____, give the following individual(s) my permission to inquire and/or received the indicated information.

NAME OF INDIVIDUAL	**INFORMATION TO RELEASE (Medical records, prescriptions, appointments, etc)**
_____	_____
_____	_____
_____	_____

Please check one of the following:

_____ This notice is effective only on the following date(s): _____

_____ This notice is effective indefinitely or until I revoke it myself in writing.

_____
Patient/Parent/Guardian (Print Name)

_____ _____
Patient/Parent/Guardian (Signature) **Date**

VERBAL CONSENT OBTAINED FROM PATIENT/PARENT/GUARDIAN

Name of Patient/Parent/Guardian: _____
Date: _____
Effective thru: _____ ***or indefinitely (unless revoked by patient/parent/guardian)***
Staff member documenting consent: _____