**THE GROBY SURGERY**

**FORM OF AUTHORITY**

**PATIENT’S NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

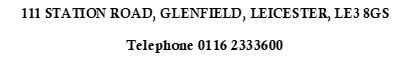
**DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***I fully consent to the person(s) named below discussing my care and medical information on my behalf, including results and prescriptions.***

|  |  |  |
| --- | --- | --- |
| **NAME OF NOMINEE** | **RELATIONSHIP TO PATIENT** | **CONTACT NUMBER(S)** |
| 1. |  |  |
| 2. |  |  |
| 3. |  |  |
| 4. |  |  |

**PATIENT SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOMINEE/S SIGNATURE:** 1. \_\_\_\_\_\_\_\_\_ , 2. \_\_\_\_\_\_\_\_\_, 3. \_\_\_\_\_\_\_\_\_ , 4.\_\_\_\_\_\_\_\_\_

**DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_