James P. Thomas, M.D. | voicedoctor.net
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With regard to my care and treatment, I give my permission for James P Thomas, MD LLC to speak with the individuals listed below (print the names of family members (and relationship), physicians, etc.) – *otherwise we can speak ONLY with you*.
This information will be used to keep other health care providers informed about your care. Please list anyone possibly calling on your behalf or anyone with whom you would like me to correspond.

Referred by: _____

Would you like us to send a copy of our office notes to them? ☐ **yes** ☐ **no**

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Primary Physician: _____

Would you like us to send a copy of our office notes to them? ☐ **yes** ☐ **no**

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Otolaryngologist (ENT): _____

Would you like us to send a copy of our office notes to them? ☐ **yes** ☐ **no**

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Other: _____ **Specialty:** _____

Would you like us to send a copy of our office notes to them? ☐ **yes** ☐ **no**

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Please list below anyone who may contact this office on your behalf (for example, your spouse, parent, friend):

Family: _____ **Relationship:** _____

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Other: _____ **Relationship:** _____

Address: _____

City: _____ State: _____ Zip: _____ — _____

Phone: (_____) _____ — _____ Fax: (_____) _____ — _____

Patient Name: _____ **Date of appointment** _____ / _____ / ____