Brockport Vine Medical

122 West Ave, Ste 6B
Brockport NY 14420
(585) 391- 3040

Patient name: _____
(please print)

I give Vine Medical my permission to communicate with the following people about my medical care:

Including: {please check all that apply}

[ ] making & breaking appointments

[ ] diagnosis information, Plan of care

[ ] medication requests / refills

[ ] patient billing

Name: (Please print)	Relationship:

I understand that this will remain in effect until I state otherwise. I can rescind this authorization at any time.

_____ _____
Signature Date

_____
Relationship (Self / Parent / Other)