Sharad R. Vyas, MD
2186 Harris Ave NE Suite 2
Palm Bay, Fl 32905

CONSENT FOR COMMUNICATION and/or DISCLOSURE

Patient's Name: _____ DOB_____

I request the following alternatives or limitations relating to communication directed to me by my healthcare provider or employee of Medical Associates of Brevard.

Do we have permission to?

May we call you at home? Yes No
If yes, may we leave the following information on your home answering machine or voicemail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

May we call you at work? Yes No
If yes, may we leave the following information on your home answering machine or voicemail?

Appointment Information Yes No

Billing Information Yes No

Medical Information Yes No

I give my permission to share the following information with the person(s) named below:

Name: _____Relationship_____
Appointment Yes No Billing Yes No Medical Yes No

Name: _____Relationship_____
Appointment Yes No Billing Yes No Medical Yes No

Name: _____Relationship_____
Appointment Yes No Billing Yes No Medical Yes No

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date