



**GASTROINTESTINAL MEDICINE ASSOCIATES, INC.**

[www.GIMEDRI.com](http://www.GIMEDRI.com)

PAUL W. RODERICK, M.D., F.A.C.G.  
THOMAS H. McGREEN, M.D.  
ROBERT WOLFGANG, D.O.  
MORRIS P. ELEVADO, M.D.  
ROBERT J. BIERWIRTH, M.D.  
COLIN WOODARD, D.O.  
DEIRDRE E. SMITH, APRN, CNP  
JENNIFER L. GEREMIA, PA-C  
JODI CUSACK, PA-C

**PERMISSION TO DISCUSS MEDICAL CARE**

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

PATIENT NAME: \_\_\_\_\_

PATIENT DATE OF BIRTH: \_\_\_\_\_

I, \_\_\_\_\_, will allow the physicians and staff at Gastrointestinal Medicine Associates, Inc. to discuss any and all issues concerning my medical care with \_\_\_\_\_

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

RELATIONSHIP TO PATIENT: \_\_\_\_\_

NOTE: Unless Gastrointestinal Medicine Associates, Inc. is notified by you in person or by certified mail, the above PERMISSION TO DISCUSS MEDICAL CARE shall remain in effect indefinitely.

When it is necessary to contact you by telephone, i.e. to confirm or cancel an appointment, to give information to you regarding a booking or test that our office has scheduled on your behalf etc., may we call the telephone numbers which you have provided, and if you are not available may we:

\_\_\_\_\_ leave a message on your answering machine  
\_\_\_\_\_ leave a message with anyone other than yourself  
\_\_\_\_\_ Name of Person or Persons \_\_\_\_\_  
\_\_\_\_\_ Anyone who answers

Telephone numbers we may call:

\_\_\_\_\_ home  
\_\_\_\_\_ work  
\_\_\_\_\_ other

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

witness: \_\_\_\_\_

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