West Michigan Endocrine
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## PEOPLE INVOLVED IN CARE

Please let us know which of your family members, friends or others can be involved in talks about your health care. The people that you list below may receive any verbal information needed to be involved in your care or to help you make decisions about your care.

**By signing this form, I give permission for the staff at West Michigan Endocrine to discuss information about me with the people listed below**:

Name _____ Relationship _____ Contact Number_____

Name _____ Relationship _____ Contact Number_____

Name _____ Relationship _____ Contact Number_____

Name _____ Relationship _____ Contact Number_____

☐ I do not give permission to anyone to receive verbal information about my care.

Is it okay to leave a voicemail message with results on your home or cell phone voicemail:

☐ Yes
☐ No

**Patient Name**_____ **Date**_____

**Patient Signature or Signature of Legal Representative**_____

*If patient is under 18 years of age signature of parent or legal guardian.*