



Patient Name: _____ Date of Birth: _____

I hereby give permission to Ringgold County Hospital and their staff to discuss my care with the following:

Name/Relation: _____ Telephone Number: _____

Name/Relation: _____ Telephone Number: _____

Name/Relation: _____ Telephone Number: _____

Name/Relation: _____ Telephone Number: _____

Name/Relation: _____ Telephone Number: _____

Name/Relation: _____ Telephone Number: _____

I hereby give permission to Ringgold County Hospital and their staff to leave messages at my telephone number(s):

- Yes
- No

Home Number: _____

Alternate Number: _____

Eye Doctor Name/City: _____

Dentist Name/City: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____