ima | Healthcare
Internal Medicine Associates

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Medical information may be released to the following:

Name: _____ Phone: _____

Relation to Patient:_____

Name: _____ Phone: _____

Relation to Patient:_____

Name: _____ Phone: _____

Relation to Patient:_____

I understand that it is my responsibility to inform IMA Healthcare of any change to the above information.

Okay to leave a message on my voicemail/answering machine?

Yes No

Patient Signature/POA: _____ Date: _____

Patient Name (please print): _____ DOB: _____

Updated: 1/11/2019