CROSSPARK MEDICAL, PLLC
200 West , 86th Street Suite 1i
New York, NY 10024

CONSENT TO DISCUSS MEDICAL CONDITION/ INFORMATION WITH OTHER INDIVIDUALS

I, ___________________________, give, Crosspark Medical, PLLC's staff and physicians permission to discuss my medical condition/ information either the individuals listed below. I understand that this consent may be revoked at any time by notifying Crosspark Medical, PLLC's in writing of my intent.

Name ___________________________ Relationship to Patient ______________________________

Name ___________________________ Relationship to Patient ______________________________

Name ___________________________ Relationship to Patient ______________________________

Name ___________________________ Relationship to Patient ______________________________

Name ___________________________ Relationship to Patient ______________________________

Name ___________________________ Relationship to Patient ______________________________

Signed: __________________________ Date____________________________________