# Consent to Treat

During your treatment with Tampa Bay Reflux Institute, it may be necessary to contact you regarding your appointments, surgery, or medical condition.

Please list family members or friends you authorize us to speak with if we cannot contact you. ***Without this authorization, we are prohibited by law from answering any questions regarding your appointments, surgery, or medical condition.*** This rule applies to spouses, children, parents, and other immediate family members.

I, ______________________________, hereby authorize the office of

Gopal Grandhige, MD and Tampa Bay Reflux Institute to contact :

____________________________________________________________

____________________________________________________________

or to leave a message at my home or office. There **are/are no** exceptions to the above.

Exceptions: __________________________________________

This authorization will last indefinitely unless this office is notified in writing about any new changes.

Signature _________________________ Date _____________

Witness _________________________

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