



Patient Instruction to Biologics

To Discuss Medical Information with Caregiver/Family/Friend

By filling out this form, I am instructing and giving permission to Biologics by McKesson (Biologics) to speak with the individual(s) identified below about health information relevant to their involvement with my health care or payment for services.

I understand my permission given to Biologics will expire one year from the date signed, as indicated below. I understand that I may cancel or change this instruction, in writing, at any time prior to its expiration. I have the right to revoke this instruction, in writing, except where disclosures have already been made, based upon my prior instruction.

It is my desire and instruction for Biologics to speak with and disclose my health information to the following individuals:

1. Name: _____

Relationship to Patient: _____ Telephone #: () _____ - _____

2. Name: _____

Relationship to Patient: _____ Telephone #: () _____ - _____

3. Name: _____

Relationship to Patient: _____ Telephone #: () _____ - _____

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	
Patient Mailing Address	Patient City, State, Zip	

Patient Date of Birth		

Mail this form to: Biologics by McKesson, 13000 Weston Parkway, Suite 105, Cary, NC 27513
Or email it to: MyCareTeam@biologicsinc.com