

PATIENT CONTACT AUTHORIZATION

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(PLEASE CHECK ALL THAT APPLY):

HOME TELEPHONE

- OK TO LEAVE MESSAGE ON HOME ANSWERING
MACHINE WITH DETAILED INFO (This includes test results,
Pre-op information, appointment date(s) and times, etc.)
 LEAVE MESSAGE WITH CALL BACK NUMBER ONLY.
 DO NOT CALL MY HOME NUMBER.

WRITTEN COMMUNICATION

- OK TO MAIL TO MY HOME ADDRESS
 OK TO FAX TO THIS # _____

WORK TELEPHONE

- OK TO LEAVE MESSAGE WITH DETAILED INFO
 OK TO LEAVE MESSAGE WITH CALL BACK NUMBER ONLY
 DO NOT CALL MY WORK

CELL PHONE

- OK TO LEAVE MESSAGE WITH DETAILED INFO
 LEAVE MESSAGE WITH CALL BACK NUMBER ONLY
 DO NOT CALL MY CELL PHONE

PLEASE BE ADVISED: WE CANNOT GIVE INFORMATION TO ANYONE WITHOUT YOUR WRITTEN CONSENT. IF YOU WANT SOMEONE ELSE (FOR EXAMPLE: YOUR SPOUSE) TO RECEIVE YOUR PERSONAL HEALTH INFORMATION, YOU MUST COMPLETE THE AUTHORIZATION TO RELEASE HEALTH AND BILLING INFORMATION FORM. I UNDERSTAND THAT I MAY CHANGE MY METHODS OF CONTACT AT ANY TIME BY WRITTEN CONSENT.

PATIENT/ GUARDIAN SIGNATURE _____

DATE _____