PATIENT CONTACT AUTHORIZATION

I, ____authorize
(Patient Name & Date of Birth)
Regional General & Vascular Surgeons to contact me in regards to my medical information via the following methods. ***(Please circle the appropriate response)***

May we contact you by cell phone? Y or N ***Primary contact number:*** Y or N

My cell phone number is: ___________________________
May we leave a voice message on a machine? Y or N
May we leave a message with whomever answers? Y or N

May we contact you by home phone? Y or N ***Primary contact number:*** Y or N

My home phone number is: _________________________
May we leave a voice message on a machine? Y or N
May we leave a message with whomever answers? Y or N

May we contact you by work phone? Y or N ***Primary contact number:*** Y or N

My work phone number is: __________________________
May we leave a voice message on a machine? Y or N
May we leave a message with whomever answers? Y or N

May we contact you by mail? Y or N

Email address: ____

Name(s) of additional people authorized to receive your medical information:

____

Signature of patient and date: ____________________________________

If personal representative please sign, date and list relationship to patient:

____

Please return form(s) prior to office visit and bring your insurance card(s).