



## Contact Form

I wish to be contacted in the following matter:

- Home
- Cell
- Work

Ok to leave detailed message at:

- Home
- Cell
- Work

Ok to leave call back number at:

- Home
- Cell
- Work

Written Communication:

- Ok to mail my medical information to my mailing address
- No, I don't want my medical information mailed.

Ok to fax information to: \_\_\_\_\_

The duration of this authorization is indefinite unless otherwise revoked in writing.

\_\_\_\_\_  
***Signature of patient or legal representative***

\_\_\_\_\_  
***Date***