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PATIENT NAME _____

Do we have permission to:

Leave a message on your answering machine at home or voice mail? Yes No

Leave a message at your place of employment? Yes No

Discuss your medical condition with any member of your household? Yes No

If yes, who: _____ Relationship _____ Contact Number _____

If yes, who: _____ Relationship _____ Contact Number _____

Others authorized to receive information about your medical condition:

Name: _____ Relationship _____ Contact Number _____

Primary Care Physician name and number

Signature _____ Date _____