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631-598-7034

Please read the directive below and select the appropriate choice for you, A or B, and sign the bottom of the page

A. I ______________________________ give the above noted medical practice its employees, my physician, and healthcare providers in the above practice, **PERMISSION TO LEAVE INFORMATION PERTAINING TO MY MEDICAL CARE ON MY CELL PHONE, HOME OR OFFICE ANSWERING MACHINE,** at the numbers listed below, **OR WITH ANY OR ALL OF THE DESIGNATED REPRESENTATIVES LISTED BELOW,** with their phone numbers and /or addresses for them if different:

Contact Numbers:
Home:______________________________
Work:______________________________
Cell:______________________________

FAMILY MEMBERS OR DESIGNANTED REPRESENTATIVE WITH CONTACT PHONE NUMBERS (if different from above) : (Please Print)

____________________ ____________________
____________________ ____________________
____________________ ____________________

B. I ______________________________DO NOT want any information pertaining to all aspects of my medical care left on my home, office or cell, phone answering device or with anyone other than myself.

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Patient signature:

______________________________Date:__________