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This is a patient instruction form to the practice for handling your important medical information. This form is revocable at patient request in writing at any time.

Patient Name ____ Date_______________
(Print)

I wish to be called at home_____ other___ (check all that apply) regarding my care and follow-up.

The best telephone number(s) to reach me are:

Home # _________________________________ Other # _________________________________

I DO___, or I DO NOT___ give permission to leave relevant medical information on my answering machine or voice mail.

I DO___, or I DO NOT___ want relevant medical information shared with the person who may answer the telephone.

The name(s) of the individual(s) with whom you may leave pertinent information are:

Name ___________________________________ Phone _____________________ Relationship _________

Name ___________________________________ Phone _____________________ Relationship _________

Name ___________________________________ Phone _____________________ Relationship _________

____ ____________________
Patient Signature Date