Palm Beach Neurology

PATIENT CONTACT CONSENT FORM

All calls from Palm Beach Neurology regarding your care, test results and appointments will be made to your home telephone number unless an alternate number is requested below. If you would like us to contact an alternate telephone number, other then number on file, please indicate below.

( ) _____

____ I hereby authorize the above-mentioned medical practice to contact me by telephone and if I am not present, they may leave a message on my answering machine.

____ **DO NOT** leave a message on answering machine other than name of caller and telephone number.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By Signing this form, you are giving person(s) mentioned below to have access to your medical condition, billing information, medical records, and speak with health care professional on your behalf.

_____	_____	_____
Name	Relationship	Telephone Number
_____	_____	_____
Name	Relationship	Telephone Number

I authorize name(s) mentioned above to have access to my medical condition, billing information and medical records on my behalf. I give them consent to speak with healthcare professional regarding my medical condition and/any billing information and access to my medical records.

Print Name:_____ Patient Signature:_____ Date:_____