

**Advanced Physical Medicine
Patient Communication Authorization**

Patient Name: _____ **DOB:** _____

Please list contact numbers:

Home: () _____
Work: () _____
Cell: () _____

IF YOU ARE NOT AVAILABLE MAY WE LEAVE A VOICE MESSAGE?

- No, do not leave a voice message
- Yes, please leave a voice message

IF YOU ARE NOT AVAILABLE – WHO MAY WE COMMUNICATE WITH?

- Communicate with self only

Please check all that apply.

Spouse (Name) _____ **Phone:** () _____

- Any Information
- Test Results
- Appointment Information
- Billing Information
- Other _____

Child (Name) _____ **Phone:** () _____

- Any Information
- Test Results
- Appointment Information
- Billing Information
- Other _____

(Name) _____ **Phone:** () _____

Relationship to patient: _____

- Any Information
- Test Results
- Appointment Information
- Billing Information
- Other _____

Signature Patient or Legal Representative

Date

Printed Name Patient or Legal Representative