Contact/Release Information

_____
Patient Name

I understand that there are some circumstances that may require you to contact me regarding my care. By initialing and signing below, I authorize Macy O&P to contact me at the following (please initial all that apply):

_____ Home phone number _____Work phone number _____ Cell phone number

I authorize Macy O&P to leave the following information as a voice message (please initial all that apply):

_____ Appointments _____ Treatment Instructions _____ Billing/Account Information

_____ Other (Please describe) _____

_____ I do not want any voice messages left

I authorize Macy O&P to share information regarding my treatment, or payment for treatment, with the following individual:

_____ My spouse or partner

_____ My son or daughter

_____ Other individual (name)

_____ _____
Name of Patient or Personal Representative Description of Personal Representative Authority

_____ _____
Signature of Patient or Personal Representative Date