Memorial Clinical Associates, P.A.
16001 Park Ten Place, Suite 300
Office: (713) 407-3000/Fax: (713) 461-3476

PATIENT CONTACT PERMISSION FORM

This information will allow us to contact you in regards to all medical results, inquiries and office/medical related issues.

Please list telephone numbers that we may use to contact you:

1. _____ (Home - Work - Cell - Other: _____)
2. _____ (Home - Work - Cell - Other: _____)
3. _____ (Home - Work - Cell - Other: _____)

In the event Memorial Clinical Associates are unable to reach you concerning your issues related to this office and/or your treatment, may we leave a message on:

1. Home Answering Machine? YES _____ NO_____
2. Work Voice Mail? YES _____ NO_____
3. Cellular Voice Mail? YES _____ NO_____

If you have provided a work telephone number for us to contact you, and you are unavailable, may we leave a message with your receptionist/operator to have you return the office's call? YES _____ NO_____

Please list the names of any person(s) to whom you give us permission to discuss anything concerning your medical status (i.e.: relative, spouse, friend.)

IF THE NAME IS NOT LISTED, WE WILL NOT DISCUSS OR RELEASE ANY INFORMATION

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Patient Name: _____ Date: _____

Signature: _____ Relationship (if not patient): _____

Address _____

_____

THIS DOCUMENT WILL EXPIRE 1 YEAR FROM SIGNATURE DATE