

Request to Communicate

I authorize the clinic indicated above to contact me regarding clinical services in the means provided below. These messages may include appointment reminders, schedule changes or other personal health information. I understand it is my responsibility to notify the clinic should this information change. **I understand I do not have to provide any of the communication sources.**

Home Phone: _____
Ex: 123-456-7890

You may leave a detailed message

Cell Phone: _____
Ex: 123-456-7890

You may leave a detailed message

Work Phone: _____
Ex: 123-456-7890

You may leave a detailed message

Email: _____

You may leave a detailed message

Please Note: If you do not mark the box to leave a message, we will not leave a message.

Please Note: If a spouse/family member/POA completes the form, their name should be listed so that we can talk to them.

Do you give permission for us to contact or leave information with another person?

Yes No

List name of person(s): _____

*You can list as many people as you would like.

Relationship of person: _____

Contact phone number: _____

Ex: 123-456-7890

Signature of Patient/Patient Representative

Date/Time

Relationship of Patient Representative



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WACS

