

**Request to Communicate**

I authorize The SpineCare Center 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 SpineCare Center should this information change. **I understand I do not have to provide any of the communication sources.**

**Home Phone:** You may leave a detailed message

 Ex: 123-456-7890

## **Cell Phone:** You may leave a detailed message

##  Ex: 123-456-7890

## **Work Phone:**  You may leave a detailed message

##  Ex: 123-456-7890

##  **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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship of patient representative:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_