CONSULTANTS IN PAIN MANAGEMENT

PRIVACY FORM

I, _____, Date of Birth: _____authorize Consultants in Pain Management to:

RE: Appointments

May we leave a message concerning your appointments? ___ YES ___ NO

____ Home Phone __ Brief __ Detailed _____ (phone #)

____ Cell Phone __ Brief __ Detailed _____ (phone #)

May we speak with or leave a message with a family member or other individual concerning your appointments? ___ YES ___ NO

RE: Returning Calls

May we leave a message when returning your call? ___ YES ___ NO

May we speak with and/or leave a message with a family member or other individual when returning your call? ___ YES ___ NO

Please specify with whom we may speak concerning **YOUR CARE**, messages, and appointments.

_____
Name Relationship

_____
Name Relationship

_____
Name Relationship

___ No one.

_____ _____
Patient Signature Date

Revised 3-8-16