



SPINE LLC

CONSENT TO LEAVE A MESSAGE OR SPEAK WITH PERSON(S) REGARDING MY MEDICAL INFORMATION

Please list the family members or other person, if any, with whom we may inform about your general medical condition and diagnosis (including treatment, payment and health care options.)

Name	Relationship	Phone Number

Please list the family members or other persons, if any, with whom we may inform about your general medical condition. **ONLY IN AN EMERGENCY**

Name	Relationship	Phone Number

Please print the address where you would like your billing statements and / or all other correspondence from our office mailed if other than your home.

Address:

I am fully aware that a cell phone is not a secure and private line.

Can confidential messages (i.e., appointment reminders) be left on your answering machine or voice mail? YES NO

Signature of Patient or Personal Representative

Date

Printed Name of Patient or Personal Representative

Date

Description of Authority of Patients Personal Representative