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Date: \_\_\_\_\_

**Contact Information and Release of Medical Information to Family and Friends**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Best phone to reach me:	May we leave detailed message?	Home	Cell	Work	Other
1): Preferred: _____	_____	_____	_____	_____	_____
2): _____	_____	_____	_____	_____	_____
3): _____	_____	_____	_____	_____	_____

With whom can our office discuss your medical information?	Billing	Medical
1.) _____	_____	_____
2.) _____	_____	_____
3.) _____	_____	_____
4.) _____	_____	_____

In case of emergency, call:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If you use one pharmacy, which one?.

\_\_\_\_\_ Address: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE