SUSAN KUPFERMAN, MD
1600 116TH Ave NE Suite 104
Bellevue, WA 98004
T: 425-454-5758
F: 425-455-4451

PHONE AUTHORIZATION

I, ____ (D.O.B.________________)
(Print your full name)

Authorize Dr. Kupferman's office to leave a message (Check all that apply)

- ❑ Home # __________ - ___________ - ___________ ❑ Work # __________ - ___________ - ___________
- ❑ Cell # ___________ - ___________ - ___________
- ❑ Another # _________ - ___________ - ___________ Name: ____________________________________

With the following information:

- ❑ My detailed confidential test results
- ❑ Specific requests for more information
- ❑ Detailed appointment information
- ❑ Other

This authorization allows Dr. Kupferman's office to leave certain specified information on the specific voice mails you have designated. You have the right to withdraw this authorization at any time and such revocation must be signed and dated below. This authorization will remain in effect until you chose to revoke it.

SIGNED____ DATE ____________________

If everything is still current, please initial and date below:

Initial _______ Date ________	Initial _______ Date ________	Initial _______ Date ________	Initial _______ Date ________	Initial _______ Date ________
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