FAMILY MEDICINE ASSOCIATES
OF NORTH STAFFORD

Patient Contact Authorization

I _____ hereby authorize Family Medicine Associates of North Stafford to discuss any and all aspects of my care and/or appointment reminders with the following person(s):

1. _____ Relation: _____
2. _____ Relation: _____
3. _____ Relation: _____
4. _____ Relation: _____
5. _____ Relation: _____

NOTE: If patient does not wish to list anyone as a contact, please write "NONE" in the space above. Please be sure to sign and date below or form is not valid.

If we are unable to contact you, may we have permission to leave a detailed message on your voicemail? Yes or No (Please circle one)

If "yes" please list your preferred number _____

I understand that I have the right to revoke this authorization at any time in writing. I understand that the revocation will not apply to information that has been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contact a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____

If I fail to specify an expiration date, event, or condition, this authorization will expire in twelve(12) months.

Signature: _____ Date: _____