North Florida Surgery Center

PATIENT CONTACT INFORMATION FORM

Patient Name: ______________________________________ Date: __________

All calls regarding your case, test results, and appointments will be made to your home telephone number or number you provide.

PLEASE CHECK ONE

____ I hereby authorize North Florida Surgery Center to contact me by telephone and if I am not available, they may leave a message on my answering machine or voice mail.

____ Do NOT leave a message other than the name of the caller and the telephone number.

OTHER CONTACT INFORMATION

The following people other than a guardian or conservator are authorized to discuss by medical condition or billing information with a healthcare professional of North Florida Surgery Center.

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(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

___________________________________ ________________

Patient Signature Date