

Patient Contact Release

Patient Name: _____ DOB: _____

I authorize the office of John E. West, M.D., P.C. to leave medical/financial information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Check those that apply:

- _____ Home Telephone
- _____ Answering Machine
- _____ Work Telephone # _____
- _____ Voice Mail # _____
- _____ Cell Phone # _____
- _____ Pager # _____

I authorize the office of John E. West, M.D., P.C. to discuss my medical/financial information with:

Spouse: _____

Parent: _____ Contact # _____

Other: _____ Contact # _____

Other: _____ Contact # _____

I authorize the office of John E. West, M.D., P.C. to mail reminders of upcoming visits, lab rechecks, lab results, and diagnostic test results to me.

I understand I can change this information at any time by making a request.

Patient/Guardian

Date