Memory Care Specialists

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COMMUNICATION RELEASE FORM

Patient Name: ____ Date of Birth ____/____/____

Address: ____

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Home Phone: _____________________________________ Work: __________________________

Cell Phone: ________________________________ Other Phone: __________________________

Your 1st Preference? □ Home □ Cell □ Work □ Other Phone □ E-Mail

E-Mail: ____

Designated/Authorized Next of Kin # 1: ____

Relationship to Patient: ____

Designated/Authorized Next of Kin # 2: ____

Relationship to Patient: ____

I give permission for messages to be delivered to me by: **(Please check ALL that apply.)**

□ U.S. MAIL □ VOICE MAIL / ANSWERING MACHINE

□ FAX □ E-MAIL

The following information can be left: **(Please check ALL that apply.)**

□ APPOINTMENTS □ LAB RESULTS
□ PATHOLOGY RESULTS □ RADIOLOGY REPORTS
□ PRESCRIPTIONS □ MEDICAL ADVICE
□ REFERRALS

____ ______________________________________
Signature (Self / Parent / Legal Guardian) Relationship to patient

____ ______________________________________
Print Name Date

***** PLEASE RETURN THIS PAGE TO US *****