Stony Creek Internal Medicine

Communications Request

_____ _____ _____

Printed Name Account Number DOB

As part of Practice Operations, we routinely contact our patients by telephone for a variety of reasons. This includes appointment scheduling and reminders, routine test results, procedure preparation and instructions, as well as responses to your questions.

We will telephone you at your home. If you are unavailable, we will leave a message on your answering machine or with whomever answers the telephone. In case of an urgent matter we will also attempt to reach you on your cell phone and/or work.

PLEASE INDICATE YOUR ACCEPTANCE OF THIS MATTER BY SIGNING BELOW.

Patient Signature _____ Date. _____

If the above manner of contact is not acceptable to you please indicate how you prefer to be contacted (i.e. alternate telephone number, email, mailing address).

_____

_____

In addition, I authorize the following people to request information on my behalf either written or verbal regarding scheduling, test results, and procedures.

Spouse _____ Significant Other _____

Sibling _____ Child. _____

Other _____

_____ _____

Patient Signature Date