

**PATIENT COMMUNICATION AUTHORIZATION**

Patient Sticker

**I authorize Dr. Merrill and/or his staff to communicate and/or leave messages for me at the following locations:**

|      |              |                         |
|------|--------------|-------------------------|
|      | (Circle One) | Phone number . . . ext. |
| HOME | yes    no    | (____)_____             |
| WORK | yes    no    | (____)_____             |
| CELL | yes    no    | (____)_____             |

**OK to leave message on voice mail / persons authorized to receive information about my healthcare:**

|       |                    |
|-------|--------------------|
| _____ | Relationship _____ |
| Name  |                    |
| _____ | Relationship _____ |
| Name  |                    |
| _____ | Relationship _____ |
| Name  |                    |

\*\*\*\*\*

In case of an emergency or we are unable to contact you, persons authorized to be contacted:  
**These contacts are not authorized to receive information about your healthcare!!!**

|                             |                             |
|-----------------------------|-----------------------------|
| <b>Emergency Contact #1</b> | <b>Emergency Contact #2</b> |
| Name _____                  | Name _____                  |
| Relationship _____          | Relationship _____          |
| Phone Number(____)_____     | Phone Number(____)_____     |

I acknowledge that this information can only be rescinded by my written authorization.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_