Minneapolis Otolaryngology, PA

Patient Name (printed): ______________________________ Date of Birth: ______________________

Telephone Communications

By completing this form you are giving Minneapolis Otolaryngology, PA permission to leave your scheduling, medical and/or billing information with the person(s) you state below and/or the answering machine/voicemail phone number(s) you provide.

I authorize Minneapolis Otolaryngology, PA to leave information on this voicemail/answering machine number:

Number	Describe Home/Work/Cell/Other	Scheduling	Medical	Billing
________________	_____________	Y N	Y N	Y N
________________	_____________	Y N	Y N	Y N
________________	_____________	Y N	Y N	Y N

I authorize Minneapolis Otolaryngology, PA to leave information with the following persons:

Name	Relationship	Scheduling	Medical	Billing
________________	________________	Y N	Y N	Y N
________________	________________	Y N	Y N	Y N
________________	________________	Y N	Y N	Y N

Emergency Contact

I authorize Minneapolis Otolaryngology, PA to contact the following person(s) in the event of a medical emergency:

Name	Relationship	Phone(s)
________________	________________	________________________________
________________	________________	________________________________

These authorizations will remain in effect until I change them in writing.

Patient Signature: ______________________________ Date: _______________