Caring for Fertility

Contact Authorization

Patient Name_______________________________ Date of Birth:_____________________

My preferred method of contact is:

Phone _____________________________________Type: ___Home___Cell___Work

Email____

From time to time we will email or leave a message for you on an answering machine, voicemail, OR with another individual in your absence (as stated in our Notice of Privacy Practices). Please, initial to give permission:

_____ Leave [ ] message/ [ ] email/ [ ] text with reminder appointment date and time
_____ Leave [ ] message/ [ ] email/ [ ] text with extensive appointment information
_____ Leave [ ] message/ [ ] email/ [ ] text regarding results, prescriptions, or other medical information
*please note data rates may apply with texting

MUST INITIAL if permission given:

_____ I am aware that email, phones, and texts are not secure or private

_____ DO NOT EMAIL OR LEAVE MESSAGE OF ANY KIND

Please let us know who we may share information with regarding your medical information to include appointments, treatment, and results:

1. Name _____________________Relation____________________Phone________________

2. Name _____________________Relation____________________Phone________________

Medical Release:
Request records to be shared with: Name:________________________Fax:_______________

Please do not include (or N/A): ____

Patient Signature____Date:__________________

If Patient is under 18 years of age: Signature__________________ Relationship____________

Staff Signature ______________________________