WARREN J. KATZ MD, F.A.C.S

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Authorization to Contact

Our office will need to contact you for various medical reasons. For instance, appointment reminders, surgical instructions, and patient forms to be completed will be sent out by this office. Please provide your contact information below and indicate your preferred method of contact.

Home Tel. ( ) _____ OK to leave a voicemail? Yes No
May we contact you at home? Yes No

Work Tel. ( ) _____ OK to leave a voicemail? Yes No
May we contact you at work? Yes No

Cell Tel. ( ) _____ OK to leave a voicemail? Yes No
May we contact you via cell? Yes No

E-Mail Address:
_____
May we contact you via email? Yes No

What is your preferred method for us to contact you? _____
May we leave a detailed message? Yes No

Please list any additional individuals we may contact, on your behalf, by providing their first and last names and their relationship to you:

_____ _____

_____ _____

_____ _____

To authorize another individual as your personal representative giving them authority to schedule, confirm, change appointments and receive information regarding your medical condition, please provide name below.

_____
First and Last Name, Relationship

_____
Patient Name (Printed)

_____
Date

_____
Signature