JOHN KLEIN MD
ORTHOPEDIC SURGEON

PATIENT COMMUNICATION AUTHORIZATION

PATIENT LEGAL NAME _____ DATE: _____

BIRTH DATE (MM/DD/YYYY) _____/_____/_____

PLEASE LIST CONTACT PHONE NUMBER:

HOME (_____) _____-_____

WORK (_____) _____-_____

CELL (_____) _____-_____

IF YOU ARE NOT AVAILABLE, MAY WE LEAVE A VOICE MESSAGE?

☐ NO, DO NOT LEAVE A VOICE MESSAGE

☐ YES, PLEASE LEAVE A VOICE MESSAGE (PLEASE CHECK ALL THAT APPLY)

- ☐ ANY INFORMATION
- ☐ TEST RESULTS
- ☐ APPOINTMENT INFORMATION
- ☐ BILLING INFORMATION

IF YOU ARE NOT AVAILABLE, WHO MAY WE COMMUNICATE WITH?

☐ COMMUNICATE WITH SELF ONLY OR (PLEASE CHECK ALL THAT APPLY BELOW)

☐ SPOUSE (NAME) _____ PHONE: (_____) _____-_____

- ☐ ANY INFORMATION
- ☐ TEST RESULTS
- ☐ APPOINTMENT INFORMATION
- ☐ BILLING INFORMATION

☐ CHILD (NAME) _____ PHONE: (_____) _____-_____

- ☐ ANY INFORMATION
- ☐ TEST RESULTS
- ☐ APPOINTMENT INFORMATION
- ☐ BILLING INFORMATION

☐ OTHER (NAME) _____ PHONE: (_____) _____-_____

(RELATIONSHIP TO PATIENT) _____

- ☐ ANY INFORMATION
- ☐ TEST RESULTS
- ☐ APPOINTMENT INFORMATION
- ☐ BILLING INFORMATION

_____

SIGN: PATIENT OR LEGAL REPRESENTATIVE

_____

PRINT: PATIENT OR LEGAL REPRESENTATIVE AND RELATIONSHIP