PREFERRED AND PERMITTED CONTACTS

For _____
(PLEASE PRINT NAME)

Please help us to communicate with you!

HOME _____ NUMBER
- □ Can leave detailed message
- □ Leave call back information only
- □ No Messages at this number

WORK _____ NUMBER
- □ Can leave detailed message
- □ Leave call back information only
- □ No messages at this number

CELL _____ NUMBER
- □ Can leave detailed message
- □ Leave call back information only
- □ No messages at this number

□ I give permission to be contacted by email. _____

□ I give permission to share test results/other information with my spouse/parent/other.

□ Speak only to me regarding any results/information.

Persons allowed to speak with

_____
NAME/RELATIONSHIP PHONE

_____
NAME/RELATIONSHIP PHONE

€ By checking this box, you are agreeing to the release of medical information/HIPAA consents in lieu of signature. We are required to collect this data to be in compliance with Medicare's requirements for Electronic Medical Records and HIPAA regulations.

_____ □ I am the parent or legal guardian
(SIGNATURE)