



**Memorial Clinical Associates, P.A.**  
 1201 Dairy Ashford Suite 200 – Houston, TX 77079  
 Office: (713) 407-3000/Fax: (713) 461-3476  
**PATIENT CONTACT PERMISSION FORM**

This information will allow us to contact you in regards to all medical results, inquiries and office/medical related issues.

Please list telephone numbers that we may use to contact you:

1. \_\_\_\_\_ (  Home -  Work -  Cell -  Other: \_\_\_\_\_ )
2. \_\_\_\_\_ (  Home -  Work -  Cell -  Other: \_\_\_\_\_ )
3. \_\_\_\_\_ (  Home -  Work -  Cell -  Other: \_\_\_\_\_ )

In the event Memorial Clinical's associates are unable to reach you concerning your issues related to this office and/or your treatment, may we leave a message on:

- |                            |           |          |
|----------------------------|-----------|----------|
| 1. Home Answering Machine? | YES _____ | NO _____ |
| 2. Work Voice Mail?        | YES _____ | NO _____ |
| 3. Cellular Voice Mail?    | YES _____ | NO _____ |

If you have provided a work telephone number for us to contact you, and you are unavailable, may we leave a message with your receptionist/operator to have you return the office's call? YES \_\_\_\_\_ NO \_\_\_\_\_

Please list the names of any person(s) to whom you give us permission to discuss anything concerning your medical status (i.e.: relative, spouse, friend.)

IF THE NAME IS NOT LISTED, WE WILL NOT DISCUSS OR RELEASE ANY INFORMATION

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship (if not patient): \_\_\_\_\_

**THIS DOCUMENT WILL EXPIRE 1 YEAR FROM SIGNATURE DATE**