Northwest Neurology

**COMMUNICATION INFORMATION:**

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|---|---|---|
| If you are unavailable at the time we contact you, may we leave information on voicemail? | Yes | No |
| Do you authorize our office to submit information to you via secure email or portal messaging? | Yes | No |

Please list any persons with whom we may share details about your health care. I understand that I may revoke this consent at any time by giving written notice of my desire to do so.

First Name:_____ Last Name:_____

Relation to Patient:_____ Phone Number:_____

First Name:_____ Last Name:_____

Relation to Patient:_____ Phone Number:_____

First Name:_____ Last Name:_____

Relation to Patient:_____ Phone Number:_____

First Name:_____ Last Name:_____

Relation to Patient:_____ Phone Number:_____

*Please sign below acknowledging that you have reviewed this information and have made necessary changes and verify its accuracy to the best of your ability.*

_____ _____

Signature of Patient or Legally Authorized Representative Date