David W. Allison, MD
Plastic and Reconstructive Surgery

Patient Contact Authorization

Patient name _______________________________DOB _________________________

In the effort to reach you efficiently and to confirm appointments, leave messages regarding your healthcare, and to discuss insurance billing issues, we are asking you to complete the following telephone contact information.

While we prefer NOT to leave messages, we would like to ensure that your medical information is properly protected as required by HIPPA guidelines. By completing the following telephone contact information this will give us your authorization to leave messages with those individuals listed at the numbers given below, if applicable. We will NOT leave messages containing sensitive health related information.

Please list the telephone numbers that are the best way to contact you and circle the phone number we should call first.

HOME: __________________________CELL: ____

WORK: __________________________OTHER: ____

Please list the names of family of friends with whom you authorize us to leave messages relating to your medical care

1. _______________________________ Relationship: ___________________________________

2. _______________________________ Relationship: ___________________________________

3. _______________________________ Relationship: ___________________________________

Please list the name and telephone number of your Pharmacy.

Pharmacy Name: ______________________Location: ____________ phone:________________

By signing below I authorize my physician or their representatives to leave messages in reference to my appointments, billing issues, prescriptions and test results on my voice mail or with the individuals listed above in the event I am not available.

PATIENT/GUARDIAN: _____________________________DATE: _______________