Suite 400 General Medical Pavilion
415 Morris Street Charleston, WV 25301
304-344-3551 Fax 304-342-6927
www.wvneuro.com

COMMUNICATIONS CONSENT FORM

______________________________ ____________________

Patient Name *Date of Birth*

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

Home Telephone #: ______________________ ☐ **Cell Phone #:**______________________

☐ OK to leave message with information ☐ Leave message with call-back number only

☐ OK to leave message at home or on the cell phone with the following family members: (list name(s) and relationship to patient)

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☐ **Work Telephone #:**______________________

☐ OK to leave message with information ☐ Leave message with call-back number only

Appointment Reminders

Our office uses an automated appointment reminder system to contact you prior to your scheduled appointment. Please indicate your preference on how we contact you:

☐ Home Phone ☐ Cell Phone ☐ Text Message

Written Communication

☐ OK to mail to my home address ☐ OK to mail to my work address

☐ OK to fax to this number: _____________ ☐ OK to send to this e-mail:______________________

Communication with Other Healthcare Providers

Patient information or medical records may be communicated to other Healthcare Providers, hospitals or insurance companies if necessary.

Please list the name, address, and phone number of health care providers that you want to receive a copy of your office visit report.

Name: ______________________________ **Name:** ______________________________

Address: ______________________________ **Address:** ______________________________

______________________________ ______________________________

Phone #: ______________________________ **Phone #:** ______________________________

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Patient or Legal Representative Signature **Date**

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(If legal representative's signature appears above, please describe relationship to the patient)