**CONTACT INFORMATION**

Please list individuals involved in your healthcare that we may contact and/or discuss your care?

NAME RELATIONSHIP PHONE NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I authorize Dr. Kellye Hudson to contact me or the individuals listed above. If necessary Dr. Kellye Hudson may leave medical information pertaining to my care by the following methods. I assume responsibility for notifying them whenever this information changes.

Yes No Address:
Yes No Phone:
Yes No Text Message:
Yes No Email:

Signature of Patient or Guardian:

Date: