

Authorization to Schedule Testing/Discuss Test Results

Patient Name: _____ DOB: _____

I authorize Tucson Gastroenterology Specialists, PC to talk to the following people regarding scheduling of my testing or my test results if I am unavailable: **(please check all that apply)**

- No one other than myself
- My Spouse _____
(Name of Spouse)
- My Child(ren) _____
(Name of Child(ren))
- Okay to leave a message on my answering machine at the following number;
Phone # (____) _____ - _____

I understand that this statement will remain in effect until I notify the office in writing on a form provided by this office of any changes.

Patient Signature _____
Date

Emergency Contact Information

Name: _____ Relationship: _____

Contact Phone Number(s): _____

Alternate/Seasonal Mailing Address

If your billing address is not the same all year long, please complete the area below so that you may continue to receive correspondence from our office. Thank you!

Address _____

City State Zip Code

The above listed address is my alternate billing address for the following time period;
From _____/_____/_____ To _____/_____/_____. (Please add a date range if possible)