Contact Authorization Form

Name:______________________________

Home Phone:___________________Cell Phone:_______________ Work Phone:

I give permission for Pierini Esthetic Surgery Center or his staff to leave messages concerning appoiment dates, treatments, payments information and other private health information:

Please indicate location:

___ on my home phone ___ on my work phone

___ on my cell phone

___ I do not give permission for Pierini Esthetic Surgery Center or staff to leave messages on my home phone, cell phone or work phone.

Please indicate below any individuals that we may release your medical information to:

Name:_________________________ Relationship:__________________ Phone:__________________

Name:_________________________Relationship:__________________Phone: _________________

By signing this statement I am giving Pierini Esthetic Surgery Center and staff consents to release my personal medical information as indicate above.

Patient Signature:_____________________ Date:___________________