Lake City Surgery Center
Permission Form

Do we have your permission to:

1.	Call you at home or at another number you provide:	☐ Yes	☐ No
2.	Leave a message or medical information on your answering machine at home?	☐ Yes	☐ No
3.	Leave a message or medical information with the person answering the phone?	☐ Yes	☐ No
4.	Call you at work?	☐ Yes	☐ No
5.	Leaving messages or medical information on your voice mail at work?	☐ Yes	☐ No
6.	Discuss your medical and/or scheduling information with another person? Person's name _____ Relationship _____ Phone Number _____	☐ Yes	☐ No
7.	Discuss your billing information with another person? Person's name _____ Relationship _____ Phone Number _____	☐ Yes	☐ No

I acknowledge that I received the Notice of Privacy Practices and have had the opportunity to read it.

_____ _____

Patient's Signature Date

_____

Witness Signature