VALERIE A. KNUDSEN, M.D.

WE WOULD LIKE TO BE ABLE TO CONTACT YOU REGARDING RESULTS FROM TESTS THAT MY HAVE BEEN DONE TODAY AT YOUR VISIT. PLEASE WRITE DOWN YOUR CONTACT INFORMATION SO THAT WE MIGHT HAVE THIS IN YOUR FILE. ALSO, PLEASE MAKE IT APPARENT TO US THAT IT IS OKAY TO LEAVE A MESSAGE AT ANY OF THESE NUMBERS. THANK YOU.

PLEASE MARK THE BOX NEXT TO THE PHONE NUMBER YOU WOULD PREFER US TO CONTACT YOU BY.

PATIENT NAME: _____

☐ **HOME PHONE: _____**
okay to leave message: YES NO (please circle one)

☐ **WORK PHONE: _____**
okay to leave message: YES NO (please circle one)

☐ **CELL PHONE: _____**
okay to leave message: YES NO (please circle one)

EMAIL ADDRESS: _____

In order to ensure that your medical records are kept safe, please provide the following information regarding who is allowed access to your medical information.
(WARNING: The member requesting your records may be asked to verify information on you to prove relation.)

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____