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EMERGENCY CONTACT

PERSON TO NOTIFY IN CASE OF EMERGENCY _____

TELEPHONE NUMBER _____

MEDICAL INFORMATION MAY BE RELEASED TO THE EMERGENCY CONTACT YES NO

RELEASE OF MEDICAL INFORMATION

I, _____, give permission to The Spine and Neuro Center to release information regarding medical care at this office, including my prescriptions, my appointments, and other medical information to the following people. I also give my permission for messages to be left on the answering machine at my home phone.

Name	Relationship	Phone Number

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I understand that every effort will be made by The Spine and Neuro Center to contact me with this information but in order to provide me with the best medical care possible, it may be necessary, in my absence, to give information to others. This release will remain in effect indefinitely or until revoked by me.

 Patient's Signature

 Date