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ALLERGY ♦ SINUS ♦ ASTHMA

Roger N. Danziger M.D.
Board Certified
Allergy / Asthma / Immunology

Patient Consent to Receive Mail, Phone Messages and/or Texts / Emails
PLEASE FILL OUT THE ENTIRE FORM. THANK YOU.

Please print (Last Name) ____________________ (First Name)_______________ (M.I.)___

Below Please let us know by which means we may contact you

	Cell/Voicemail	Email or Text	Home phone/Voicemail
Appointment information	Y_____ N_____	Y_____ N____	Y_____ N____
Billing information	Y_____ N_____	Y_____ N____	Y_____ N____
Medical information	Y_____ N _____	Y_____ N____	Y_____ N____

Please list anyone you would like us to share your private information with. If you do not list your spouse, child, relative, friend we will not be able to speak with them on your behalf.

I give permission to share appointment information with the person(s) named below:

Name: ____

I give permission to share medical information including biopsy and lab results with The person(s) listed below:

Name: ____

I give permission to share billing information with the person(s) listed below:

Name: ____

Signature of Patient / Guardian / Parent: ____________________

Date: ____________

Patient Home # : __________________ Patient Cell # : __________________

Patient Email: ______________________

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