REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name: _____
(Please Print)

Date of Birth: _____

I request that all communications to me (by telephone, mail or otherwise) by Ray W. Ng, D.P.M., P.A. and/or its staff is handled in the following manner:

For Written Communications: Address To: _____

_____

_____

For Oral Communications: Call: _____
(Telephone Number)

May we leave a message? (Yes) (No)

MEDICAL CONSENT

Consent is hereby given to Dr. Ray W. Ng, D.P.M., P.A. to discuss my medical information or medications with the following member or caregiver:

_____

_____

_____

Patient Signature: _____ Date: _____