



Personal Care Associates

Communication Authorization

Patient: _____

Last

First

Middle

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Preferred times to call: _____

Work Phone: _____ Ext: _____ Office Hours: _____

Cell Phone : _____ Preferred times to call: _____

Voice Mail? _____ Is it confidential? _____ Pager: _____

E-mail Address: _____ Is it confidential? _____

I, hereby authorize Personal Care Associates to contact me at any and all of the above numbers and addresses, during the hours stated. Confidential messages may be left on the following: (check all that apply)

- Home
- Work
- Cell Phone
- E-mail
- Pager

Patient Signature: _____ Date: _____