Brain & Spine Specialists
Neurological Associates, Inc.

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415 Morris Street
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Phone: (304) 344-3551 Fax (304) 342-6927
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COMMUNICATIONS CONSENT FORM

_______________________________ _______________________
Patient Name Date of Birth

I give permission to be contacted in the following manner (please fill in phone numbers and check all that apply)

☐ **Work Telephone:**

☐ OK to leave message with information

☐ Leave message with call-back number only

☐ **Home Telephone:**

☐ OK to leave message with information

☐ Leave message with call-back number only

☐ OK to send e-mail to this address:

☐ OK to leave message at home with the following family members:

☐ **Written Communication**

☐ OK to mail to my home address

☐ OK to mail to my work address

☐ OK to fax to this number:

☐ **Cell Phone:**

☐ Patient information or medical records may be faxed to other Care Providers, hospitals or insurance companies if necessary.

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Patient or Legal Representative Signature **Date**

If a legal representative's signature appears above, please describe legal representative's relationship to the patient.

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