BEND DERMATOLOGY
CLINIC

Do we have permission to:

Leave a message on your voicemail? _____Yes _____No

Leave a message at your place of employment? _____Yes _____No

Discuss your medical condition with a household member? _____Yes _____No

If yes, with whom: _____ **Relationship**: _____

Contact Phone Number: _____

_____ _____ _____

Patient (*or responsible party*) Signature | Patient Name (print) | Date