Progressive Laser LLC

"Science enhancing Beauty..."

Authorization to Share Information

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Patient name _____ DOB _____

Leave appointment and billing messages on/with:

Answering Machine?	___ Yes ___ No
Office Voice Mail?	___ Yes ___ No
With another Person?	___ Yes ___ No
Sent through the mail?	___ Yes ___ No
Send via email?	___ Yes ___ No
Cell Phone?	___ Yes ___ No

If you answered YES to allowing us to discuss your appointment or billing information with another person, please list their names(s), relationship(s) and phone # below:

Name: Relationship: Phone: Cell Phone:

_____

_____

_____

_____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

_____DATE _____

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP:

_____DATE _____