Marialyn J. Sardo, MD, FACS
Certified, American Board of Plastic Surgery

Patient Communication Consent

PLEASE PRINT

I, _____ _____/_____/_____
(Name of Patient or Guardian) (Date of Birth)

hereby request Marialyn J. Sardo, M.D. to keep communication regarding my health information confidential by adhering to the following communication options:

Contact me at the numbers listed below:

Home Phone Number: (_____) _____-_____
Work Phone Number: (_____) _____-_____
Cell Phone Number: (_____) _____-_____

_____ Do not contact me via phone. I will be responsible for communicating with the office.

If I am not available at the time of your call: ***You may leave a message and medical information on my answering machine or voicemail:***

Home: _____Yes _____No
Work: _____Yes _____No
Cell: _____Yes _____No

_____ Do not leave medical information on my answering machine or voicemail.

You may also leave a message and medical information with the following person(s):

Name: _____ Relationship: _____ Phone: (_____) _____-_____
Name: _____ Relationship: _____ Phone: (_____)_____-_____

_____Only leave medical information with me, the patient or guardian.

Contact me at this email address: _____
_____ Do not contact me by email.

Signature: _____ Date:_____/_____/_____

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