

Charleston Internal Medicine, Inc  
3701 MacCorkle Avenue, SE  
Charleston, WV 25304  
304-720-2345

### Authorization to contact by phone

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_

Please circle the appropriate authorization(s)

- |     |    |   |
|-----|----|---|
| Yes | No | I may be contacted by telephone at home when necessary  |
| Yes | No | I may be contacted by telephone at work when necessary  |
| Yes | No | I may be contacted by phone at this emergency number: _____   |
| Yes | No | A message regarding test results, scheduling, billing, or return telephone calls to my physicians may be left on my answering machine/voice mail or can be given to persons at my home who are authorized to answer my telephone. |
| Yes | No | Patient information or medical records may be faxed to other care providers, hospitals, medical facilities, diagnostic testing facilities, or insurance companies when necessary.   |

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date