CONTACT INFORMATION

DANIEL BENDETOWICZ, M.D., P.A.

EMERGENCY CONTACT:

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

NON-EMERGENCY CONTACT:

You may be contacted to remind you of appointments, questions regarding insurance, discuss results of your tests or to talk about your medical conditions. Is there someone else to whom Daniel Bendetowicz, M.D., P.A is authorized to disclose the above information? If yes, provide this person's name and contact information below.

❑ _____ **If same as above, it is not necessary to repeat all the information. Please check here and initial.**

Name: _____

Relation to the patient: _____

Address: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____ Cellular Phone Number: _____

This authorization will remain in effect until I cancel it in writing.

By signing this form, I authorize the disclosure of the information as above. I acknowledge I have reviewed and understand this authorization form.

Signature: _____ Date: _____

NAME _____ **DATE OF BIRTH** _____