



521 N WILMA AVENUE STE A
RIPON, CA 95366

TELEPHONE 209-599-4211
FAX 209-599-7348

www.RiponFP.com

AUTHORIZED CONTACTS

Patient _____ Birth Date _____

I give permission for the office staff to speak to and share detailed information regarding my medical care with the following individuals:

Name: _____ Phone: _____ Relationship to patient: _____

If applicable: Emergency Contact Durable Power of Attorney for Healthcare (*provide copy*)

Name: _____ Phone: _____ Relationship to patient: _____

If applicable: Emergency Contact Durable Power of Attorney for Healthcare (*provide copy*)

Name: _____ Phone: _____ Relationship to patient: _____

If applicable: Emergency Contact Durable Power of Attorney for Healthcare (*provide copy*)

NO AUTHORIZED CONTACTS

Signature of Patient/Guardian/Representative _____ Date _____

If this authorization is NOT signed by the patient, complete the following information:

Printed Name _____ Relationship to Patient _____ Representative's Phone # _____