

## CAREGIVER CONTACT & AUTHORIZATION FORM

### 1. PATIENT INFORMATION

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

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Physician (optional): \_\_\_\_\_

### 2. PRIMARY CAREGIVER / LEGAL GUARDIAN

Name: \_\_\_\_\_

Relationship: ☐ Parent ☐ Guardian ☐ Spouse ☐ Other: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Mobile Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_

Best Time/Method to Reach: \_\_\_\_\_

### 3. SECONDARY CAREGIVER / EMERGENCY BACKUP (optional)

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Contact #: (\_\_\_\_) \_\_\_\_-\_\_\_\_

### 4. AUTHORIZED PICKUP LIST

Individuals allowed to pick up the patient, receive discharge instructions, or transport medications.

1) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

2) Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_

### 5. DECISION-MAKING AUTHORITY

☐ Primary caregiver may consent to all medical treatments on behalf of the patient.

☐ Authority limited to the following: \_\_\_\_\_

### 6. COMMUNICATION PREFERENCES

☐ Clinic may leave detailed voicemail messages.

☐ Clinic may email test results to caregiver.

☐ Clinic may send SMS appointment reminders.

### 7. SIGNATURES

I affirm that the above individuals may act according to the permissions granted.

Patient or Legal Representative Signature: \_\_\_\_\_ Date \_\_\_\_\_

Witness (clinic staff): \_\_\_\_\_ Date \_\_\_\_\_