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 _____