



Bariatric & Laparoscopy Center of Ocala
Patient – Contact Information

I wish to be contacted in the following manner (initial all that apply):

Home Telephone: _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Work Telephone _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Cell Telephone _____

_____ O.K. to leave a message with detailed information
_____ Leave message with call back number only

Written Communication

_____ O.K. to mail to my home address
_____ O.K. to mail to my work/office address
_____ O.K. to fax to this number _____

Personal Contacts

O.K to release Protected Health Information (PHI) to the following:

Name: _____ Relationship _____
Name: _____ Relationship _____
Name: _____ Relationship _____

I understand it is my responsibility to change this information should my circumstances change. I will notify Bariatric & Laparoscopy Center of Ocala in writing of any changes to the above.

_____ I have received and understood the Notice Of Privacy Practices

Signature

Date