

# Marana Health Centers, Inc.

## CONTACT CONSENT FORM

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Patient Name

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Date of Birth

May our office staff leave any telephone message on your home answering machine?  Yes  No

At your workplace?  Yes  No

Please list the names of any individuals that our office staff has permission from you to release (verbal and written) medical information.

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Name

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Relationship & Phone Number

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Patient Signature

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Date

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Witness Signature

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Date