

Lourdes Breast Care Center Telephone Contact/Family Member Information Release Consent

Patient Name _____ Date of Birth _____

Home Telephone Number _____ May we leave a message? _____

Work Telephone Number _____ May we leave a message? _____

Cellular Telephone Number _____ May we leave a message? _____

Yes, I do give permission to the Lourdes Breast Care Center staff to release information concerning my care to the following family members:

Name and relationship

Name and relationship

Name and relationship

Name and relationship

Patient Signature and date

Witness signature and date