Leon Springs Pediatrics

Communication Authorization Request

I wish to be contacted in the following manner regarding my child/children (check all that apply)

____Home Telephone_____ ___Written Communication

____OK to leave message with detailed information ___OK to mail to my home address

____Work Telephone_____ ____Other_____

____OK to leave message with detailed information

____Leave message with call back number only

_____ _____

Patient/Parent/Guardian Signature

_____

_____

_____ _____

Date Patient Names (s)