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Patient's Name: _____ MRN _____

CONSENT FOR COMMUNICATION IN REGARDS TO CARE

I give permission to **SCHAFFER, SCHONHOLZ & DROSSMAN, LLP** to contact me for follow-up phone calls, call backs, medical information, test results, appointment related calls and to leave voice mail messages and send emails in regards to care at **SCHAFFER, SCHONHOLZ & DROSSMAN, LLP** using the information provided below:

Telephone # 1 _____ Home Cell

Telephone # 2 _____ Home Cell

Email: _____@_____.com

Patient's Signature _____ Date: _____