NSPC
Brain & Spine Surgery

BENJAMIN R. COHEN, M.D., F.A.C.S.

PATIENT COMMUNICATION CONSENT FORM

I agree to allow Dr. Cohen and his staff to contact me using the following methods regarding my personal health information, evaluation and treatment. I authorize/do not authorize Dr. Cohen and his staff to leave messages for me when I am unavailable as indicated below.

Check to Confirm Approval of Method	Method	Number/Address	Leave Messages
_____	Home Phone	(_____) _____-_____	☐ Yes ☐ No
_____	Cell Phone	(_____) _____-_____	☐ Yes ☐ No
_____	Work Phone	(_____) _____-_____	☐ Yes ☐ No
_____	Alternate Phone	(_____) _____-_____	☐ Yes ☐ No
_____	Email	_____@_____	☐ Yes ☐ No

I authorize Dr. Cohen and his staff to discuss my personal health information with the individuals listed below. I understand that by leaving spaces blank, I am indicating my choice that I do not want my information shared with or released to anyone else.

Name	Relationship to Patient	Phone Number
_____	_____	(_____) _____-_____
_____	_____	(_____) _____-_____
_____	_____	(_____) _____-_____

EMERGENCY CONTACT ONLY:

Name: _____ Phone: _____

By my signature below, I hereby acknowledge that I have read and understand the information provided on this Consent Form. I understand the risk associated with different methods of communication, especially email, and consent to the communications outlined in this Consent Form.

_____ _____
Patient Name Printed Date

_____ _____
Patient/Authorized Signature Relationship to Patient