PALM BEACH NEUROLOGICAL CENTER
3365 BURNS RD, SUITE 203
PALM BEACH GARDENS, FL. 33410
MICHAEL M. TUCHMAN, M.D. DEBRA KULCHYCKI, NP

PATIENT RESULTS AUTHORIZATION

PATIENT NAME: _____PT #_____

All calls from **Palm Beach Neurological Center** regarding your care, test results and appointments will be made to your home phone number unless an alternate number is requested. If you would like us to contact you at an alternate phone number, please provide that number below.

( )_____

_____ I hereby authorize the above-mentioned medical practice to contact me by phone and if I am not present they may leave a message on:
Please check

___ Home answering machine

___ Cell phone voicemail

___ Work voicemail

___**DO NOT** leave a message on any phone number other than name of call and phone number.

_____ I herby authorize the above-mentioned medical practice to contact me by email:
(Initial)

_____@_____

_____ _____
Signature of Patient Date

_____ _____
Witness Date