GREAT LAKES SURGICAL ASSOCIATES
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Jeffrey F. Smith, M.D., F.A.C.S.
Ernest A. Cudjoe, M.D., F.A.C.S.

Patient Name: ____

On this date, I authorize Great Lakes Surgical Associates to contact me or leave a message at: *(PLEASE CIRCLE)*

Home: Yes No
Work: Yes No

Home Number: _________________________ Work Number: _____________________

On this date, I ___________________________________, do hereby grant permission for my physician or his staff to give permission regarding any and all treatment results to:

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

Name: ________________________________ Relationship: ________________________

I understand this contact permission form is to be placed in my medical chart and used for the expressed purposes herein.

Patient Signature: ____________________________________ Date: _______________

This form is valid for one year from date signed.