

# SOUTHERN CALIFORNIA VASCULAR ASSOCIATES

A MEDICAL CORPORATION

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Vascular and Endovascular Surgery

## Okay to leave message request

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Alt#:** \_\_\_\_\_

I give permission to leave a message on my answering machine. **Yes** \_\_\_ **No** \_\_\_

I hereby give my permission to leave any Medical Information to include treatment, payment, appointments and health care operations with the following person (s):

<u>Name:</u>	<u>Relationship:</u>	<u>Phone #:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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SUITE 505  
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