CARONDELET
Foothills
SURGERY CENTER

2220 W. Orange Grove Road
Tucson, AZ 85741
520-877-5660

PATIENT CONTACT DESIGNATION

Following your surgery, your physician will need to speak to a family member or your designated representative to provide information on the outcome of your surgery and/or to give instructions for your postoperative care.

I, _____, give permission for Carondelet Foothills Surgery Center to provide patient information for myself, or child _____, to the following person(s);

1. _____Phone # _____
2. _____Phone #_____

The information divulged should pertain **only to today's date of service** _____, and only regarding the procedure performed **today**. This is **not** consent for release of your medical records.

I understand that all patient information is confidential and protected under the Health Insurance Portability and Accountability Act except to the person(s) designated above.

Please check the box that is your preferred choice for contact by Carondelet Foothills Surgery Center personnel:

Can we contact you at: ☐ Work ☐ Home ☐ Cell
Can we leave a message at: ☐ Work ☐ Home ☐ Cell

(*We will never leave personal health information on your home message machine*)

Signature: _____ Date: _____

Witness: _____ Date: _____

Patient sticker