GENESIS
Neuroscience Clinic

Patient Contact Information

To ensure we are able to respond to you in a timely manner when you contact us, please provide the following:

Preferred Phone Number: _____

Cell Phone Number: _____

Email Address: _____

If you would like to receive reminders and/or confirmation regarding appointments, prescription refills or other information, please note your preferred method of communication. You may choose more than one.

❑ Voice Messages Please note preferred time to call. ❑ Morning ❑ Afternoon ❑ Evening

❑ Email

I authorize Genesis Neuroscience Clinic to disclose my protected health information to:

❑ Family member(s) (List): _____ Ph #: _____

_____ Ph #: _____

❑ Non-family member(s) (List): _____ Ph #: _____

❑ Myself only

I authorize the practice to disclose only the following protected health information to the individual(s) listed above:

_____ Test results, reports, and general health updates

_____ Appointment information only

Patient Signature _____ Date _____

1400 Dowell Springs Blvd, Suite 100 Knoxville, TN 37909
Phone: 865-888-9494 Fax: 865-444-7672