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ALTERNATIVE CONTACT REQUEST FORM

Patient's Name _____ Date of Birth: _____

Address: _____

I hereby request that Creative Hands Occupational Therapy contact me about the patient only in the following manner:

Parent's Printed Name: _____

Signature of Parent/Guardian: _____ Date: _____

Legal Authority is: ___ Parent ___ Guardian (Legal Document Needed)

Witness: _____ Other: (specify) _____