

## Communications

I authorize Loree Schweiger Nicholas D.D.S., P.C. to communicate and/or leave messages for me at the following locations and with the authorized person/s.

Authorized person's name and relationship to patient:

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Home phone# \_\_\_\_\_ Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Written communications: Addresses of Authorized Person/s

Name and relationship \_\_\_\_\_

Email \_\_\_\_\_

Home Address \_\_\_\_\_

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Name (Please Print)

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Signature

Date