RONALD W. ROSENQUIST, M.D.
Urology

Name _____

I have been notified regarding Dr. Rosenquist's privacy practices.

I give permission for Ronald W. Rosenquist, M.D. to share medical information regarding me and my care with: (*spouse, family member, caregiver)

_____ _____

_____ _____

If I need to be contacted by phone, please contact me only at:
Home _____
Work _____
Cell phone _____
**You have my permission to leave a message/voice mail ☐ Yes ☐ No

Written communications should be sent to me at:
Home
Other: _____

_____
Signature Date