

**David Gilboe and Associates, Inc.**  
23161 Greater Mack Ave  
St. Clair Shores, MI 48080  
(586) 779-8892

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I hereby give permission to David Gilboe and Associates, Inc., to:

1. Leave a message on my recorder/voice mail at home: Yes \_\_\_\_\_ No \_\_\_\_\_
2. Leave a message with my spouse/other person if I am not available:  
Yes \_\_\_\_\_ No \_\_\_\_\_
3. Leave a message at my place of business: Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
Patient Signature (if minor, parent or guardian)

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Witness