William L. Caton III, M.D. Inc.
Ian B. Ross, M.D., Inc.
Southern California Neurosurgical Associates, Inc.
630 South Raymond Avenue, Suite 330
Pasadena, CA 91105
626-793-8194

CONSENT TO CONTACT PATIENT

I, _____, authorize the medical offices of William L. Caton III, M.D. and Ian B. Ross, M.D.to contact me at the following numbers. By signing this form, I consent to Dr. Caton's and Dr. Ross's office to contact me and if necessary to leave a message regarding my scheduled appointments and medication.

Dr. Caton and Dr. Ross and their office staff can contact me and leave a message , if necessary, at the following numbers:

_____(primary)

_____(secondary)

I understand the I can withdraw my consent at anytime. I understand that I must provide written notice to Dr. Caton and Dr. Ross should I wish to withdraw my consent.

_____(Patient Signature)

_____(Printed Name)

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_____(Date)