

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

Please Print (Last Name) (First) MI

Do we have permission to:

Send a recall appointment reminder to your home Y ___ N ___

Leave the following information to you home answering machine/voice mail/cell phone:

Appointment information Y ___ N ___
Billing information Y ___ N ___
Medical information Y ___ N ___

If no to any of the above, I request that all telephone calls be made to phone # _____

Leave appointment information with the person answering the phone in your home when you are out: Y ___ N ___

Leave the following information on your work answering machine/voice mail/cell phone:

Appointment information Y ___ N ___
Billing information Y ___ N ___
Medical information Y ___ N ___

Please note medical information includes lab test results, x-ray results, more testing is required or additional information is needed from another physician's office.

I give permission to share appointment information with the person named below:

Name _____

I give permission to share medical information with the person named below:

Name _____

I give permission to share billing information with the person named below:

Name _____

Print Patient Name

Print Name of Legal Representative

Signature of Patient/Legal Representative

Date Signed