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PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

LAST NAME:_____**FIRST NAME:**_____

DO WE HAVE PERMISSION TO:

Send a yearly appointment reminder and/or test result to your home? Y_____N_____

Call you at home? Y_____N_____

Call you at work? Y_____N_____

Leave messages on your home phone? Y_____N_____

Leave messages on your work phone? Y_____N_____

Leave medical information on your answering machine? Y_____N_____

At home? Y_____N_____ At work? Y_____N_____

Communicate with you by email? Y_____N_____ email address_____

Share your medical and/or appointment information with another person? Y_____N_____

Share your billing information with another person? Y_____N_____

Name of person_____

Relationship_____

CALLING HOURS: 8:00a.m. to 5:00 p.m. Y_____N_____

Patient's Signature_____ Date_____