Patient Consent to Receive Mail, E-Mail, and/or Phone Messages

Last name First name

Home Phone Work Phone Cell Phone E-mail address

Primary Care Dr. _____ **Referring Dr.** _____

Do we have your permission to:

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

Appointment information Yes_____ No_____
Billing information Yes_____ No_____
Medical information Yes_____ No_____

Leave the following information on your work voice mail:

Appointment information Yes_____ No_____
Billing information Yes_____ No_____
Medical information Yes_____ No_____

	Leave the following on e-mail:		Regular mail:	
Appointment information	Yes_____	No_____	Yes_____	No_____
Billing information	Yes_____	No_____	Yes_____	No_____
Medical information	Yes_____	No_____	Yes_____	No_____

I give permission to share appointment information with the people listed below:

Name:_____

I give permission to share medical information with the people listed below:

Name:_____

I give permission to share billing information with the people listed below:

Name:_____

Signature of patient **Date**