

Patient Consent to Receive Mail and/or Telephone Messages

Please Print (Last Name)

(First Name)

(M.I.)

Do we have your permission to:

Send test results to your home? Yes ___ No ___

May we call you at home? Yes ___ No ___

If Yes, leave the following information on your Home answering machine/voice mail:

Appointment Information: Yes ___ No ___

Billing Information: Yes ___ No ___

Medical Information: Yes ___ No ___

May we call you at work? Yes ___ No ___

If Yes, leave the following information on your work answering machine/voice mail:

Appointment Information: Yes ___ No ___

Billing Information: Yes ___ No ___

Medical Information: Yes ___ No ___

I give my permission to share appointment information with the person(s) named below:

Name: _____ Phone #: _____

Relationship: _____

I give my permission to share medical information with the person(s) named below:

Name: _____ Phone #: _____

Relationship: _____

I give my permission to share billing information with the person(s) named below:

Name: _____ Phone #: _____

Relationship: _____

Patient Signature

Date