Patient Consent t Receive Mail and/or Telepl. ne 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