

Please read carefully and print clearly.

I, _____ give my permission to my provider/provider's staff to discuss any medical issues concerning me to:

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

Name: _____ Relationship: _____ Phone No. _____

I, _____ give my permission to my provider/provider's staff to leave a message on my home or cell answering machine or to any person answering my home or cell phone.

I, _____ give my permission to my provider/provider's staff to send text or email reminders about appointments, lab work to be scheduled, referrals or balances due on my home email or cell phone. (No medical information will be sent only a message to call our office.)

I, _____ give my permission to my provider/provider's staff to fax any information regarding me to another physician's office that may be covering for my provider, or that I may be referred to by my provider. I also give permission for my provider to contact my pharmacy _____ (pharmacy name and city) regarding any prescriptions.

I, _____ give my permission to my provider/provider's staff to contact me at my place of employment. If I am unable to be reached there, I give permission to my provider/provider's staff to leave a message for me to return their call.

If there is anything I do not want to be discussed or a message to be left at my home/cell or place of employment I will notify my provider/provider's staff in writing. If there is a change to this consent, I will also notify my provider/provider's staff in writing.

Patient Name

Signature (Parent or Guardian if Minor)

Date