

PHONE MESSAGE CONSENT

Your physician or other staff members may need to contact you. Please fill out the information below.

NAME _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

In an effort to protect your privacy, we have developed a policy regarding leaving medical information.

We will not leave messages with anyone except the patient or legal guardian
We will not leave any information on an answering machine
We will not leave any messages on a voice mail....

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and consider carefully whom you want to have access to your medical information.

I, _____ give Alpine Women's Healthcare permission to leave phone messages regarding my medical care at the following numbers. My medical care may be discussed with the person(s) listed below.

My cell voice mail _____ Initial

My home answering machine _____ Initial

My office/work voice mail _____ Initial

Spouse (name) _____ Initial

Other (names) _____ Initial

_____ Initial

_____ Initial

Signature _____ Date _____

PLEASE INDICATE WHICH # IS BEST TO REACH YOU DURING OUR OFFICE HOURS.