

PHONE MESSAGE CONSENT FORM

Your physician and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

****UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:**

LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.

LEAVE INFORMATION ON AN ANSWERING MACHINE.

LEAVE INFORMATION ON A VOICE MAIL.

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

I, _____ give Pinnacle Women's Healthcare my permission to leave phone messages re: my medical care and test results with the following individual(s). I fully understand that this consent will remain in effect until revoked in writing.

My cell phone () _____ - _____ initial _____

My home answering machine/voice mail () _____ - _____ initial _____

My office/work voice mail () _____ - _____ initial _____

My spouse: _____ () _____ - _____ initial _____

Other: _____ () _____ - _____ initial _____

Signature: _____ Date: _____