PATIENT CONSENT TO RECEIVE MAIL AND/ OR TELEPHONE MESSAGES

PATIENT NAME: ____

DO WE HAVE PERMISSION TO:

Send a yearly appointment card to your home? **Yes**_________ **No**_______

Send test results to your home? **Yes** _________ **No**_______

Leave the following information on your work answering machine/ voicemail:

Appointment information: **Yes**_________ **No**_______

Billing information: **Yes**_________ **No**_______

Medical Information: **Yes**_________ **No**_______

I give permission to share **appointment** information with the person listed below:

Name: _______________________________ **Relationship:** _______________________

I give permission to share **medical** information with the person listed below:

Name: _______________________________ **Relationship:** _______________________

I give permission to share **billing** information with the person listed below:

Name: _______________________________ **Relationship:** _______________________

Signature of Patient: ______________________________________ **Date:** __________________