How Can We Reach You?

HealthONE Clinic Services

PHONE MESSAGE CONSENT

Your provider will at times need to contact you. By filling out the information below we will be better able to serve you.

Name: _____

In an effort to protect your privacy, we will have developed a policy on leaving medical care messages:

- We will ***NOT*** leave messages with anyone except the patient or legal gaurdian.
- We will ***NOT*** leave any confidential 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 carefuly whom you authorize to have access to protected information regarding your care.

I, _____ give HealthONE my permission to speak with and/or leave messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

My **Home** answering machine: #_____ Initials: _____

My **Cell** voice mail: #_____ Initials: _____

My **Office/Work** voice mail: #_____ Initials: _____

Other Contacts:

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Contact Name: _____ Relationship: _____

Phone#: _____ Initials:_____

Signature: _____ Date: _____