FANNO CREEK
CLINIC

CONSENT TO LEAVE PERSONAL HEALTH INFORMATION BY VOICEMAIL

☑ Please check one of the following:

☐ I give my consent to Fanno Creek Clinic physicians and staff to leave detailed voicemail messages regarding my medical information, diagnostic or laboratory results, and/or financial information at the following phone numbers:

My Home: ( ) _____ My Cell: ( ) _____

☐ I **do not** consent to receiving detailed voicemail messages regarding my medical information at home, on my cell phone, or at any other number.

_____ _____
Signature of patient/authorized representative | Patient's date of birth

_____ _____
Print patient name | Date

_____
Relationship to patient