Phone Message Consent

Your physician(s) 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, send emails and/or fax.

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

I _____give MedFlorida Medical Centers my permission to leave phone messages, send emails or fax anything regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing.

Phone Message Consent Continued

My cell phone: (_____) _____ initials _____

My home answering machine/voice mail: (_____) _____ initials _____

My office/work voice mail: (_____) _____ initials _____

My email: _____ initials _____

My fax: (_____) _____ initials _____

My medical care may be discussed with the following:

My_____: _____at (_____) _____ initials _____

Relationship Name of Person

_____

Patient/Guardian Signature

AUTHORIZE & RELEASE: *To the best of my knowledge, the question on this form has been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform thenecessary services I may need.*

Signature:_____ Date:_____