



HIPAA CONSENT
CONSENT TO LEAVE MESSAGE

Patient Name: _____
(print)

Date: _____

I wish to be called at home ; other (check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

_____ home

_____ other

I do , I do not give permission to leave relevant medical information on my answering machine or voice mail.

I do , I do not want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

Patient Signature

Date