

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 guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any message on a voice mail.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully 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: _____