Associates in Women's Health

Consent to Leave Phone/Email/Mail Messages

At times, we may need to contact you about test results, appointments, referrals or billing/insurance information. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed the following policy on leaving medical care messages. Unless we have written permission to do so:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave detailed messages on a voicemail or answering machines
- We will NOT send emails/mail messages

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, _____ DOB:_____ give my permission for Associates in Women's Health to leave phone message and or email/mail messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

How would you prefer to receive normal test results? (Please choose **ONE** option)

☐ Email (please print clearly): Email Address:_____

☐ Phone Phone Number: _____

☐ Mail Mailing Address:_____

May we leave a phone message to inform you that test results are available, give appointment reminder or with billing questions and to contact our office for more information? Please indicate the appropriate phone number below.

Home Phone: _____ ☐ Yes ☐ No

Work Phone: _____ ☐ Yes ☐ No

Cell Phone: _____ ☐ Yes ☐ No

Who else may we share your test results/medical information with on your behalf?

Spouse/Partner: ☐ Yes ☐ No If yes, name: _____

Son/Daughter: ☐ Yes ☐ No If yes, name: _____

Other: ☐ Yes ☐ No If yes, name: _____

Signature: _____ Date: _____