PERMISSION TO GIVE MEDICAL INFORMATION

Do we have your permission to leave a message on your voicemail with a family member or legal representative regarding appointments, billing, or other matters regarding your treatment?

YES _____ NO _____

Phone Number: _____

ACKNOWLEDGEMENT

I acknowledge that I have read the Notice of Privacy Practices. A copy will be provided if needed.

_____

Print Patient's Name

_____

Patient/ or Guardian (with noted relationship) Signature Date