TOTAL
FAMILY CARE

PHONE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling in the information below, we will be able to serve you better.

UNLESS WE HAVE YOUR WRITTEN CONSENT TO DO SO, WE WILL NOT:

- Leave messages with anyone except the patient or legal guardian.
- Leave information on an answering machine
- Leave information in a voicemail box

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

I give Total Family Care my permission to leave phone messages 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.

My cell phone: (_______) ________-__________ **initials** _______

My home answering machine/voicemail: (_______) ________-__________ **initials** _______

My office/work voicemail: (_______) ________-__________ **initials** _______

MY MEDICAL CARE MAY BE DISCUSSED WITH THE FOLLOWING:

My spouse: ____

at (_______) ________-__________ **initials** _______

OTHER: ____

at (_______) ________-________ **initials** _______

____ ___________________________

Patient/Guardian Signature **Date**