Contact Permission

Your physician, or office staff, may need to contact you at times. By filling out the information below, we will be better able to serve you.

PATIENT NAME:____________________________________

In effort to protect your privacy, we have developed a policy in reference to leaving messages Containing medical information.

- ❖ We will NOT leave a message with anyone except the patient or legal guardian.
- ❖ We will NOT leave any information on an answering machine or voice mail.

UNLESS….
We have your written permission.

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

I,_________________________________ give Center for Voice and Swallowing Services My permission to leave a phone messages regarding my medical care and/or billing (including appointment reminders) at the following phone number….

Home Answering Machine: #____
Office voice mail: #____
With My Spouse: #____
Other: #____

____ ____________________
Signature Date