

ASPEN CREEK MEDICAL ASSOCIATES

PHONE MESSAGE CONSENT

From time-to-time in caring for our patients, it may be necessary or desirable to contact patients by phone. When you are not available for us to speak to directly, we like to leave messages where possible.

In order to protect your privacy:

- . We will not discuss any medical information with anyone except the patient or legal guardian.
- . We will not leave any medical information on an answering machine.
- . We will not leave any medical information on a voice mail system.
- . We will attempt to, as a courtesy, leave a reminder message regarding an appointment.

UNLESS

We have your written permission to leave messages for you. Please read the information below and consider whom you want to have access to your medical information, such as test results. Please fill out only **ONE** of the following sections below.

I DO CONSENT TO LEAVE DETAILED MESSAGES:

I, _____ give ASPEN CREEK MEDICAL ASSOCIATES, and their staff my permission to leave phone messages regarding my medical care with the following:

My home phone answering machine # _____

My work phone voice mail # _____

My spouse (name) _____

Other (name) _____

Signature: _____ Date: _____

I DO NOT CONSENT TO LEAVE DETAILED MESSAGES:

I, _____, wish to be contacted personally and **I do not authorize** detailed messages regarding my medical care be left on an answering machine, voice mail, or with others.

Signature: _____ Date: _____