

 HIPAA CONSENT TO LEAVE MESSAGE

Patient Name: Date:

# (print)

I wish to be called at home­­­­­­­­\_\_\_; other \_\_\_(check all that apply) regarding my care and follow-up. The best telephone number(s) to reach me are:

 Home Other



I do\_\_\_\_, I do not\_\_\_ give permission to leave relevant medical information on my answering machine or voice mail.

I do \_\_\_, I do not \_\_\_ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individuals(s) with whom you may leave pertinent information are:



Patient Signature Date