FAMILY MEDICINE WEST

CONTACTING YOU

Patient's Name _____ DOB_____

Date: _____

Contact Number:

Home: _____ Work: _____

Mobile: _____

There may be occasions in which our office needs to contact you concerning your appointment, diagnostic testing results, billing problems or any other situations relating to your visit at our office. Please read and answer the following questions.

I give permission to this office to call the ***home number*** I've listed above and leave test results, appointments, and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

I give permission to this office to call the ***mobile number*** I've listed above and leave test results, appointments and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

I give permission to this office to call the ***work number*** I've listed above and leave test results, appointments and other information pertaining to me to anyone answering the telephone or on an answering machine.

YES **NO**

If you believe someone other than yourself may be calling the facility regarding your care, we ask that you list both the name and the relationship of the caller so that we have written permission to speak with them on your behalf.

☐ **I do not want information released to anyone other than myself, including my spouse.**

1._____ 2._____

3. _____ 4. _____

Check the information we may release to this person(s):

- ☐ **Appointment Info**
- ☐ **Account Information**
- ☐ **Medical Records**