



HIPAA CONSENT  
CONSENT TO LEAVE MESSAGE

Patient Name: \_\_\_\_\_  
(print)

Date: \_\_\_\_\_

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 individual(s) with whom you may leave pertinent information are:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date