HOPE Neurology

# Consent for Healthcare Messages

I_____give permission to the physicians and their staff at Hope Neurology to leave messages regarding my healthcare in as indicated below when I am not available.

Please check the appropriate boxes to indicate your selections.

❒ May **ONLY** leave information with me and not anyone else. (If you check here, no other choices below should be marked).

❒ May leave appointment reminders on my answering machine/voice mail.
❒ May leave lab results on my answering machine/voice mail.
❒ May leave general questions/information on my answering machine/voice mail.

Please list your contact numbers and which is your preferred method to reach you.

❒ Home _____
❒ Cell _____
❒ Work _____
❒ Other_____

Please check what information we may share about you then list who can receive that information below. The individual(s) you list will also be able to pick up prescriptions on your behalf if you are unable to.

❒ May leave appointment reminders to be given to the following person(s).
❒ May leave lab results to be given to the following person(s).
❒ May leave general questions/information to be given to the following person(s).
❒ I prefer that all healthcare messages be given to the following person(s).

| Name | Relationship | Phone Number |
|---|---|---|
| | | |
| | | |
| | | |

_____ _____

Patient or Guardian Signature Date