



# Summit Medical Group

## Consent for Healthcare Messages

Account #: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

I \_\_\_\_\_ give permission to the physicians and  
(please print patient name)

their staff at Summit Medical Group to leave messages regarding my healthcare in the following manner when I am not available:

\_\_\_\_\_ May **ONLY** leave information with me. (If you check here, no other choices should be marked, skip to the Contact Information section below ).

**(Please mark all that apply – If you checked the box above then these should be blank)**

\_\_\_\_\_ 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.

If any are checked below, please list the name of the individual we may give information to:

\_\_\_\_\_ May leave appointment reminders to be given to the following person.

\_\_\_\_\_ May leave lab results to be given to the following person.

\_\_\_\_\_ May leave general questions/information to be given to the following person.

\_\_\_\_\_ I prefer that all healthcare messages be given to the following person.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

### **Contact Information:**

I would prefer to be contacted at: \_\_\_\_\_ Home # \_\_\_\_\_

\_\_\_\_\_ Cell # \_\_\_\_\_

\_\_\_\_\_ Work # \_\_\_\_\_

\_\_\_\_\_ Other# \_\_\_\_\_

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date