8/29/2016

SOUTH COAST FAMILY MEDICAL CENTER, INC.

PHONE MESSAGE CONSENT FORM

Your physician(s) and other staff members will, at times, need to contact you. By filling out the information below, we will be better able to serve you.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO, WE WILL NOT:

- **LEAVE MESSAGES WITH ANYONE EXCEPT THE PATIENT OR LEGAL GUARDIAN.**
- **LEAVE INFORMATION ON AN ANSWERING MACHINES**
- **LEAVING INFORMATION ON A VOICEMAIL**

Please read below and consider carefully whom you want to have access to your medical information.

I, _____ give South Coast Family Medical Center, Inc. my permission to leave phone messages regarding my medical care and test results with the following individual(s) and/or answering systems. I fully understand that this consent will remain in effect until revoked in writing by me.

My cell: (_____) _____-_____ Initials _____

My home answering machine/voicemail: (_____) _____-_____ Initials _____

My office/work voicemail: (_____) _____-_____ Initials _____

My medical care may be discussed with the following people:

My significant other: _____ at (_____) _____-_____
First and last name
Initials _____

My parent(s): _____ at (_____) _____-_____
First and last name
Initials _____

Other: _____ at (_____) _____-_____
First and last name
Initials _____

Other: _____ at (_____) _____-_____
First and last name
Initials _____

_____ Date: _____
Patient or guardian