



Front Range Internal Medicine

Telephone Information AND Consent

Information:

Patient's Name _____

Please number 1 – 3 the best numbers to reach you during business hours:

_____ Home phone number (_____)_____

_____ Work phone number (_____)_____

_____ Cell phone number (_____)_____

Consent:

Your physician or other staff members of Front Range Internal Medicine may need to contact you by telephone. In an effort to protect your privacy, we have developed a policy regarding medical information over the telephone.

1. We will **NOT** leave messages with anyone except the patient or legal guardian unless we have permission to do so.
2. We will **NOT** leave any information on an answering machine or voice mail unless we have permission to do so.
3. If you prefer you may receive your health information through another method (fax, alternate address, or email)

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

I (*print name* _____), give Front Range Internal Medicine permission to leave phone messages regarding my medical care at the following phone numbers. I also give Front Range Internal Medicine permission to discuss my medical information, in person or over the telephone with the person(s) listed below:

	YES / NO	Pt Initials
My Home answering machine / voice mail	_____	_____
My Work answering machine / voice mail	_____	_____
My Cell phone voice mail	_____	_____
Spouse (provide name and phone number below)	_____	_____
_____	_____	_____
Other persons (provide name and phone number below)	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature

Date