

South Metro Obstetrics & Gynecology

PHONE MESSAGE CONSENT

South Metro Obstetrics & Gynecology will need to contact you for various reasons. By filling out the information below, we will be able to better serve you.

NAME: _____

In an effort to protect your privacy, South Metro Obstetrics & Gynecology has developed a policy on discussing your medical care or leaving voice messages regarding your medical care, including your health information, laboratory results, test results and/or your financial information:

- We will **NOT** leave messages with anyone except the patient or legal guardian except to remind you of your appointment date and time.
- We will **NOT** leave any information on an answering machine except to remind you of your appointment date and time.
- We will **NOT** leave any information on voice mail except to remind you of your appointment date/time.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO. Please read below and consider carefully whom you want to have access to your medical information.

I, _____ give South Metro Obstetrics & Gynecology my permission to discuss my medical care or leave phone messages regarding my medical care with the following people using the following contact information. I understand that medical care includes my health information, laboratory results, test results and/or financial information. I fully understand that this consent will remain valid until revoked in writing.

Myself at my Home / Answering Machine: # _____ Initials _____

Myself on my Cell Phone / Voice Mail: # _____ Initials _____

Myself at my Office / Work Voice Mail: # _____ Initials _____

OTHER:

Name: _____ Relationship: _____ # _____ Initials _____

Name: _____ Relationship: _____ # _____ Initials _____

Name: _____ Relationship: _____ # _____ Initials _____

HIPAA Acknowledgment

I affirm that I have received or read the HIPAA policies of South Metro Obstetrics & Gynecology including the Notice of Privacy Practices and any questions that I had, have been answered to my satisfaction.

SIGNATURE of Patient or Guardian _____ DATE: _____