SOUTH HILLS DERMATOLOGY

PHONE MESSAGE CONSENT FORM

Your provider(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 machine.
- Leave information on a voice mail.

I ____ give South Hills Dermatology my permission to leave phone messages regarding my medical care and test results with the following individuals(s) and/or on answering systems. I fully understand that this consent will remain in effect until revoked in writing.

______ My cell phone#: _________________________________

______ My home answering machine/voice mail#: _____________________________

My medical care may be discussed with the following:

My spouse/significant other____________________________Phone#_______________________

Other ____________________________ Relationship to patient ________________________________

Phone# ____

SIGNATURE:_______________________________________ DATE:_____________________