

# Consent Form



In order to maintain patient confidentiality, please indicate below with whom our office can or cannot leave a message.

Please circle one where appropriate:

Spouse: Yes NO if yes, Name: \_\_\_\_\_

Significant other: Yes NO if yes, Name: \_\_\_\_\_

Children: Yes NO if yes, Name: \_\_\_\_\_

Relative: Yes NO if yes, Name: \_\_\_\_\_

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

What is your preferred callback number (circle one):

Home: \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Answering machine message: Yes No

If yes, can the doctor or office staff (including billing) leave a detailed message?

Yes No, callback number only

Are you able to receive calls at your place of work?

Yes No

If you have voicemail at work, may we leave a detailed message?

Yes No, callback number only

*Please be advised that should a relative or friend contact our office, we are not at liberty to discuss your case without this permission, unless we determine that an emergency situation exists.*

*Thank you for helping us to insure your privacy.*

*Summit Breast Care*