Gallian Medical Group

Consent for Healthcare Messages

DOB: ___/___/___

I _____ give permission to the physicians and their staff at Gallian Medical Group to leave messages regarding my healthcare in the following manner when I am not available. Please check the appropriate boxes to indicate your selections.

Please list your contact numbers and which is your preferred method to reach you.

ρ Home ρ Cell ρ Work ρ Other

ρ May ONLY leave information with me and not anyone else. (If you check here, no other choices below should be marked).

ρ May leave appointment reminders on my answering machine/voice mail.
ρ May leave lab results on my answering machine/voice mail.
ρ May leave general questions/information on my answering machine/voice mail.

Please check what information we may share about you then list what person(s) can receive that

information in the table following. The person(s) you list will also be able to pick up prescriptions

on your behalf if you are unable to.

ρ May leave appointment reminders to be given to the following person(s).
ρ May leave lab results to be given to the following person(s).
ρ May leave general questions/information to be given to the following person(s). ρ I prefer that all healthcare messages be given to the following person(s).

Name	Relation	Phone Number

Patient or Guardian Signature_____Date_____

Witness Signature_____Date_____