



Summit Medical Group

Consent for Healthcare Messages

I _____ give permission to the physicians and their staff at
(please print patient name)
Summit Medical Group to leave messages regarding my healthcare in the following manner when I
am not available:

(Please mark all that apply)

- _____ May **ONLY** leave information with me. (If you check here, no other choices should be marked).
- _____ May leave appointment reminders on my answering machine/voice mail.
- _____ May leave appointment reminders with my family.*
- _____ May leave lab results on my answering machine/voice mail.
- _____ May leave lab results with my family.*
- _____ May leave general questions/information on my answering machine/voice mail.
- _____ May leave general questions/information with my family.*

*If any are checked above, please list name of individual we may give information to:

Name: _____ Relationship: _____

_____ I prefer that all healthcare messages be given to the following person (family member, guardian, caretaker or significant other):

Name: _____ Relationship: _____

I would prefer to be contacted at: _____ Home # _____
_____ Work # _____
_____ Cell # _____
_____ Other # _____

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____