

HOW CAN WE REACH YOU?

Your physician and other staff members will at times need to contact you.
By filling out the information below, we will be better able to serve.

Name: _____
Home/Evening Phone: _____
Work/Daytime Phone: _____
Cell Phone: _____

COLUMBINE FAMILY PRACTICE, P.C. PHONE MESSAGE CONSENT

In an effort to protect your privacy,
We have developed a policy on leaving medical information.

- We will NOT leave messages with anyone except the patient or legal guardian
 - We will NOT leave any information on an answering machine.
 - We will NOT leave any messages on a voice mail.

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and carefully consider whom you want to have access to your medical information.

I, _____ give Columbine Family Practice, P.C. my permission to leave phone messages regarding my medical care with the following. I fully understand that this consent will remain until revoked in writing.

My Home Answering Machine: # _____ Initials _____

My Cell Voice Mail: # _____ Initials _____

My Office/Work Voice Mail: # _____ Initials _____

My Spouse: _____ # _____ Initials _____

Other: _____ # _____ Initials _____

I acknowledge I completed this form and have received a copy of Columbine Family Practice's Notice of Privacy Practices.

Signature: _____

Date: _____