

Notification of Medical Information Patient Authorization

Please provide a telephone number where you would like to receive automated calls about your appointments, lab results, x-ray results, or other health care information.

Cell phone: _____

Home phone: _____

Work phone: _____

Can messages, including test results, be left on your telephone answering machine or voicemail?

I understand that a cell phone is NOT a secure and private line

Yes _____

No _____

Patient Name

Date

Patient Signature

Pharmacy # _____