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 you.

Name: ____

Home/Evening Phone _______________________________

Work/Daytime Phone _______________________________

Cell Phone ____

Email ____

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 protected information on any voicemail
- We will not leave any information via email

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 messages regarding my medical care with the following. I will notify Columbine Family Practice, P.C. in writing if this information changes. 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 of Patient/Responsible Party Date