Summit Medical Group

Consent for Healthcare Messages

Account # _____ DOB: ___/___/___

I _____ give permission to the physicians and their staff at Summit 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.

- ☐ May **ONLY** leave information with me and not anyone else. (If you check here, no other choices below should be marked).
- ☐ May leave appointment reminders on my answering machine/voice mail.
- ☐ May leave lab results on my answering machine/voice mail.
- ☐ May leave general questions/information on my answering machine/voice mail.

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

- ☐ Home _____
- ☐ Cell _____
- ☐ Work _____
- ☐ Other _____

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.**

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

Name	Relation	Phone Number

Advance Directive (Living Will/Power of Attorney):

Have you completed your Advance Directive? If so, does this office have a copy?

☐ Yes ☐ No

Would you benefit from speaking with someone to help you complete your Advance directives?

☐ Yes ☐ No

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____