memorial regional health

Consent to Leave Messages

Please fill out form completely

Patient Name: ____ **Date:** ______________________

I give permission to Memorial Regional Health (MRH) to leave voicemails with the following information on my answering machine, at the number I have provided to this Facility:

[ ] Appointment Information
[ ] Medical Instructions
[ ] Treatment/Diagnosis Information
[ ] Test Results
[ ] Billing Information

I give permission to MRH to release information to the following person(s):

Name: _______________________________________ Relationship: ____________________
Name: _______________________________________ Relationship: ____________________
Name: _______________________________________ Relationship: ____________________

I give permission to MRH to release the following information to the person(s) listed above:

[ ] Appointment Information
[ ] Medical Instructions
[ ] Treatment/Diagnosis Information
[ ] Test Results
[ ] Billing Information

The person(s) listed above may also:

[ ] Pick up my prescriptions or paperwork
[ ] Schedule or change my appointments

I would prefer to have No Contact from Memorial Regional Health:

[ ] Do NOT call me.
[ ] Do NOT leave messages.

Signature: ____ **Date:** ______________________