



The Spine Center

OF DUPAGE MEDICAL GROUP

PHONE MESSAGE INFORMATION RELEASE

1. Please list your preferred phone numbers.

Home _____ **Cell** _____ **Work** _____

2. Which phone number is best to use during the day (8am-4pm) **Home** **Cell** **Work**

3. Which phone number is best to use in the evening (4pm-7pm) **Home** **Cell** **Work**

4. Check box if we may leave detailed messages on your voicemail.

Home **Cell** **Work** **Do Not Leave Messages on Voicemail**

5. Check box if we may leave detailed lab/test results on your voicemail.

Home **Cell** **Work** **Do Not Leave Messages on Voicemail**

6. Please list your preferred pharmacy.

Pharmacy Name: _____

Pharmacy location &/or phone: _____

Please list any persons with whom we MAY leave detailed messages including lab results.

Only Myself

Name	Relationship

Answering machines and voice mail must have an identifying message to confirm these are your numbers for example; "You have reached John Doe"

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

SIGNATURE _____

DATE _____

PRINTED NAME _____

PATIENT, PARENT OR GUARDIAN