Patient Name_____

**MESSAGE AUTHORIZATION**

WARNER WELLNESS INSTITUTE

_____

(Name of Provider/Clinic)

considers patient confidentiality to be of utmost importance and concern. In an effort to ensure that your privacy is protected, please read and sign the following consent form.

## AUTHORIZATION

I authorize the provider/clinic to leave on my **home** answering machine, telephone number_____ or information left on my **work** voicemail, telephone number_____; pertaining to the following (check all that apply):

____ Date and time of upcoming appointment

____ Laboratory results (e.g., blood test, Pap smear, urine or other cultures)

____ X-ray, CT scan, MRI or other radiological results

____ Reminder to schedule recurring screening services or testing (e.g., Pap, annual)

____ Email Address_____ for information related to

our office including upcoming office promotions.

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my telephone messaging system.

**Signed: _____Date: _____**

## NO AUTHORIZATION

_____I **do not** authorize any messages related to my health care to be left on my **home** answering machine.

_____I **do not** authorize any messages related to my health care to be left on my **work**

voicemail/answering machine.

**Signed: _____Date: _____**

## AUTHORIZATION REVOKED

Message authorization revoked on_____

Initials of individual receiving written revocation: _____