Consent for Verbal Release of Information

Northwest Pulmonary and Sleep Medicine, will, at times, need to contact you via telephone. Ouf office would like permission to leave a voicemail message and/or messages with designates individual(s).

1. Please list your preferred telephone numbers:
   Home: _____ Cell: _____ Work: _____
2. Which phone number is best to use during the day (8am-4pm)? **Please circle your answer.**
   Home Cell Work
3. Which phone number is best to use in the evening (4pm-9pm)? **Please circle your answer.**
   Home Cell Work
4. On which phone numbers may we leave voicemail messages regarding appointment reminders? **PLEASE BE ADVISED THAT IF YOU CHOOSE A PHONE NUMBER WHERE VARIOUS PEOPLE ANSWER THE PHONE, THAT SOMEONE OTHER THAN YOURSELF MAY RECEIVE THE APPOINTMENT REMINDER. Please circle your answer.**
   Home Cell Work
5. Our office will send you a text message reminder about your appointment. If you do not give us permission to do this, please indicate the same.
   We may send you a text message We may not send you a text message
6. Please list any persons with whom we MAY share DETAILS about your health care. Indicate whether this may include sensitive health information (SHI) such as mental health, AIDS/HIV, STD treatment and drug/alcohol abuse.

Name	Relationship	Release PHI?
		Yes No
		Yes No
		Yes No
		Yes No

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through Northwest Pulmonary and Sleep Medicine. I understand that I may revoke this consent at any time by giving written notice to this office. I also understand that I will not be able to revoke this consent in cases where Northwest Pulmonary and Sleep Medicine have already relied on it to use or disclose my health information.

_____ _____ _____

Signature of Patient or Legal Guardian Printed Name Date

_____

Legal Guardian's Relationship to Patient