



**HOW CAN WE REACH YOU?  
PHONE MESSAGE / EMAIL/FAX CONSENT**

Diversified Radiology, at times, may need to contact you. By filling out the information below, we will be better able to serve you. In an effort to protect your privacy and follow federal guidelines, we have developed a policy on leaving medical care messages. Unless we have written permission to do so:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave messages on voice mail or answering machines.
- We will **NOT** send emails.

Please read below and carefully consider who, if anyone, you want to have access to your medical/account information.

I, \_\_\_\_\_ give my permission to leave phone messages and/or email/fax messages regarding my medical care/account information. I fully understand that this consent will remain valid until revoked in writing by me.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we contact you via email? Yes  / No

Fax Number: \_\_\_\_\_ May we fax results/information to you? Yes  / No

**May we leave a detailed message?**

Home Phone: \_\_\_\_\_ Yes  / No

Work Phone: \_\_\_\_\_ Yes  / No

Cell Phone: \_\_\_\_\_ Yes  / No

**Who may we speak to on your behalf?**

Spouse/Partner Yes  / No  If Yes, Name: \_\_\_\_\_

Son/Daughter Yes  / No  If Yes, Name: \_\_\_\_\_

Friend/Neighbor Yes  / No  If Yes, Name: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_