Patient Consent to Receive Mail and/or Telephone Message

PATIENT NAME: _____
(LAST) (FIRST) (MIDDLE)

Orthotic & Prosthetic Centers has my permission to:

Send a yearly appointment reminder card to my home	Y	N
Send test results to my home	Y	N
Send test results to my home	Y	N

Leave the following information on my home answering machine/voice mail:

Appointment Information	Y	N
Billing Information	Y	N
Medical Information	Y	N

Leave the following information on my work answering machine/voice mail:

Appointment Information	Y	N
Billing Information	Y	N
Medical Information	Y	N

I give permission to share appointment information with the person(s) listed below:

Name (s): _____
_____

I give permission to share medical information, including biopsy and lab results with the person(s) listed below:

Name (s): _____
_____

I give permission to share billing information with the person(s) listed below:

Name (s): _____
_____

Patient Signature: _____ Date: _____