Pacific Frontier Medical, Inc.
Patient Consent to Leave Messages

Date: _____

Patient Name: _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY)

I, _____ grant authorization for Dr. Steven J. Harris and the staff of Pacific frontier medical, Inc. to leave confidential medical information specifically as follows: (items checked indicate my consent)

All Medical Information:

Phone _____Answering Machine or Voicemail _____Fax _____Email _____

Only selected Medical Information:

A) Lab/test results
Phone _____Answering Machine or Voicemail _____Fax _____Email _____

B) Chart Information
Phone _____Answering Machine or Voicemail _____Fax _____Email _____

C) Medical Information
Phone _____Answering Machine or Voicemail _____Fax _____Email _____

Please use the following number(s) and email to relay any messages:

Home Phone:_____Mobile Phone:_____

Other Phone:_____Fax Number:_____

Email Address: _____

By signing, the patient or the legal guardian is confirming that the above reflects their request of how our office communicates medical information regarding this patient.

Print Patient Name:_____ Date:_____

If Minor, Print Parent Name: _____

Signature:_____