College Park Family Care Center P.A.

TELEPHONE COMMUNICATION REQUEST FORM

Patient's Name: _____ DOB: _____

From time to time, it is necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave a detailed telephone message regarding medical (i.e. lab/test results) or billing* information when possible. **It should be noted that our current Notice of Privacy Practice does allow us to call you with a courtesy reminder of any upcoming appointment(s).** We also will leave the **minimum** necessary information that we believe is appropriate in order to keep you informed in your healthcare partnership with us. In order to protect your privacy, we need your written permission where we can leave a **detailed** voice mail regarding your medical or billing information.

I, _____ (please print your name), give College Park Family Care Center staff/providers permission to leave telephone messages regarding my medical care/billing using one or more of the following options below until I rescind this directive in writing.

Signature _____ Date _____
(Adult Patient 18 or older or Parent/Legal Guardian)

Please check and complete the information for each selection you wish us to use.

☐ Home answering machine (Number) _____

☐ Work phone (Number) _____

☐ Cell phone (Number) _____

☐ Spouse (Name)_____ (Number)_____

☐ Other (Name)_____ (Number)_____

If you completed this for a patient, please indicate your relationship to the patient: _____

If you are completing this Telephone Communication Request Form for a dependent child under the age of 18, please list the following:

Mother's Name: _____ Father's Name: _____

***If you are 18 or over and covered under a parent/guardian's insurance plan, the owner of the policy may receive billing information.**

Send to the Front Office for entry. Place in monthly file.

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