



Summit Medical Group Consent for Healthcare Messages

Account # _____ DOB: ___/___/___

I _____ give permission to the physicians and their staff at Summit Medical Group to leave messages regarding my healthcare in the following manner when I am not available. Please check the appropriate boxes to indicate your selections.

<input type="checkbox"/>	May ONLY leave information with me and not anyone else. (If you check here, no other choices below should be marked).
<input type="checkbox"/>	May leave appointment reminders on my answering machine/voice mail.
<input type="checkbox"/>	May leave lab results on my answering machine/voice mail.
<input type="checkbox"/>	May leave general questions/information on my answering machine/voice mail.

Please list your contact numbers and which is your preferred method to reach you.

Home _____

Cell _____

Work _____

Other _____

Please check what information we may share about you then list what person(s) can receive that information in the table following. The person(s) you list will also be able to pick up prescriptions on your behalf if you are unable to.

<input type="checkbox"/>	May leave appointment reminders to be given to the following person(s).
<input type="checkbox"/>	May leave lab results to be given to the following person(s).
<input type="checkbox"/>	May leave general questions/information to be given to the following person(s).
<input type="checkbox"/>	I prefer that all healthcare messages be given to the following person(s).

Name	Relation	Phone Number

Advance Directive (Living Will/Power of Attorney):

Have you completed your Advance Directive? If so, does this office have a copy?
Yes No

Would you benefit from speaking with someone to help you complete your Advance directives?
Yes No

Patient or Guardian Signature _____ Date _____

Witness Signature _____ Date _____