

Ear Nose and Throat Consultants of East Tennessee

Consent for Healthcare Messages

I _____ give permission to the physicians and their staff at Ear Nose and Throat of East Tennessee to leave messages regarding my healthcare in the following manner when I am not available:

(Please mark all that apply)

___ May **ONLY** leave information with me. (If you check here, no other choices should be marked).

___ May leave appointment reminders on my answering machine/voicemail.

___ May leave appointment reminders with my family.*

___ May leave lab results on my answering machine/voicemail.

___ May leave lab results with my family.*

___ May leave general questions/information/account information on my answering machine/voicemail.

___ May leave general questions/information/account information with my family.*

*If any are checked above, please list name of individual we may give information to:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

___ I prefer that all healthcare messages be given to the following person (family member, guardian, caretaker or significant other):

Name: _____ Relationship: _____

I would prefer to be contacted at: ___ Home # _____

___ Work # _____

___ Cell # _____