Summit Medical Group

Consent for Healthcare Messages

Account # _____DOB: ___/___/____

I _____give permission to the physicians and their staff at

Summit Medical Group to:

Initial chosen options:

TEXT / VOICE Messages for General Healthcare Information

_____ leave **text and voice** messages at the following phone numbers for appointment reminders, office hours, general office reminders, and point of care notifications regarding my healthcare when I am not available. Cell _____ Phone _____

_____ leave **voice messages** regarding my health information including results and diagnostic information, payments of balance, care plans, referrals, when I am not available at the following number.

Cell _____ Phone _____

Sharing of Your Health Information and Results

_____ I give permission to the physicians and their staff at Summit Medical Group to share my health information including results, diagnoses, and appointment information with the following person(s).

The persons you list will also be permitted to pick up prescriptions on your behalf if you are unable.

Name	Relation	Phone Number
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Patient Signature _____Date_____

Parent or Guardian Signature _____Date_____

Witness Signature _____Date _____

Rev 10/17