

Contact/Message Consent Form

By signing below, you are consenting for the staff of RMACT to call you at the numbers provided by you. If the staff of RMA cannot speak with you directly, by signing this consent, you are agreeing to information being left on your answering machine or voice mail. This form will also allow you to grant us permission to leave a detailed message or test results with your partner, spouse or other family member. This information may be about your treatment, test results, medication instructions or other important detailed information, which may include protected health information. You have the right to cancel or withdraw this consent at any time. Please notify the Front Desk staff of your decision to cancel or withdraw this consent.

Patient Name: _____
(Please Print)

Date of Birth: _____

Contact Information

Please indicate below where we may leave a detailed message, as described above:

Phone #: _____

Is this: Home Work Cell Other _____

Authorized Person

Please print name of authorized person with whom we may discuss your protected health information:

Name: _____

Relationship: Spouse/partner Family Member Friend Parent

⇒ Patient Signature: _____

Date: _____ (Not valid unless dated)

ONLY SIGN BELOW TO CANCEL OR WITHDRAW CONSENT

I, _____, cancel/withdraw this consent.

Signature: _____ Date: _____