Magic City
FAMILY MEDICINE

Consent to Release Information

Patient Name: _____ Date of Birth: _____

Guardian/Parent Name: _____

In caring for our patients, it may be necessary for Magic City Family Medicine to contact you by telephone. When you are not available to speak to directly, we like to leave messages when possible.

In Order to protect privacy, it is Magic City Family Medicine's policy to: • Not leave messages with anyone except the patient or legal guardian • Not leave specific information on an answering machine/voice mail system unless we have permission to do so.

Please review the information below and consider carefully whom you chose to have access to your medical information, such as scheduling information, picking up prescriptions, about an upcoming procedure, inquiries about your insurance or billing information.

Please check applicable ways for us to reach you/leave messages for you.

CONSENT: Please check all that apply and provide the number if not already listed in your chart.

Home telephone or answering machine/voice mail (detailed message) _____

Office Telephone or office voice mail (detailed Message) _____

Cell Phone (detailed message) _____

Spouse (detailed message) _____

Name: Mother (detailed message) _____

Name: Father (detailed message) _____

Name: Other: _____

If you have any questions, please call Magic City Family Medicine at (406) 558-3458.

I have the option to update and/or change my preferences of how to contact me at any time by completing a NEW PATIENT CONTACT CONSENT FORM or otherwise putting my request in writing and submitting it to Magic City Family Medicine.

Patient/Guardian signature _____ Date: _____

ONLY SIGN BELOW IF YOU ARE DENYING CONSENT TO BE CONTACTED

I wish to be contacted personally and DO NOT AUTHORIZE Magic City Family Medicine to leave detailed messages with any other person or via answering machine/voice mail system.

Patient/Guardian signature _____ Date: _____