# Patient Consent to receive Mail and/or Telephone Messages

*Please Print* (Last Name) (First Name) (M.I.)

**Do we have your permission to:**

Send a recall appointment reminder to your home? Y_____ N_____

Leave the following information on your home answering machine/voice mail:

Appointment information Y_____ N_____
Billing information Y_____ N_____
Dental/Medical information Y_____ N_____

Leave the following information on your work answering machine/voice mail:

Appointment information Y_____ N_____
Billing information Y_____ N_____
Dental/Medical information Y_____ N_____

I give permission to share appointment information with the person named below:

Name: _____

I give permission to share dental/medical information with the person named below:

Name: _____

I give permission to share billing information with the person named below:

Name: _____

_____ _____
Signature of Patient Date