REGENCY HEALING MEDICAL CLINIC

Healing And Preserving Our Community

Permission to Release Information Specific to Voice Mail

In addition to the information contained within Regency Healing Medical Clinic Acknowledgement of Privacy Practices, I give permission to my RHMC physician's office personnel to leave messages on my home answering machine and/or cell phone in regard to my/my Child's routine and/or NORMAL laboratory and/or NORMAL radiology results. I realize that I might not be the only person to hear such a message about me/my child:

□ **Yes,** I give permission to leave messages on my home answering machine and/or cell phone for reasons as stated above (**This permission is good for one year or until otherwise revoked by me)**

_____Home # for messages

_____Cell # for messages

□ **No,** do not leave messages about me/my child on my home answering machine and/or cell phone.

_____ _____

Patient Name (please print) Date of birth

_____ _____

Signature of Patient or patient's legally authorized representative Date

_____ _____

Printed Name of authorized representative Relationship to patient

_____ _____

Witness Date