PROVIDER-PATIENT CONTACT CONSENT FORM

I, _____, DOB _____/_____/_____ consent and agree that
(PLEASE PRINT YOUR NAME HERE)

My provider may contact me and leave voice messages as outlined below. These messages can include appointment information, billing information, and information that identifies me as a mental health provider.
I understand that if I choose the option for callback information only, a message will be left solely with a first name, and callback telephone number.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK OFF ONE BOX FOR EACH PHONE NUMBER):

Home Telephone Number and/or answering machine number: _____-_____-_____

- ☐ I consent to messages with detailed information as outlined above (no restrictions)
- ☐ Leave messages with first name and callback number only (restricts the message)
- ☐ Do not leave messages at my home telephone number

Work Telephone Number and/or Answering Machine Number: _____-_____-_____

- ☐ I consent to messages with detailed information as outlined above
- ☐ Leave messages with first name and callback number only
- ☐ Do not leave messages at my work telephone number

Mobile Telephone Number and/or Answering Machine Number: _____-_____-_____

- ☐ I consent to messages with detailed information as outlined above
- ☐ Leave messages with first name and callback number only
- ☐ Do not leave messages at my mobile telephone number

***Text/e-mail (unable to ensure secure message delivery)

- ☐ I consent to messages through text messaging to my mobile phone
- ☐ I consent to messages through e-mail: _____

ADDRESS WHERE PRIVATE HEALTH INFORMATION CAN BE MAILED TO YOU:

Street:_____

City, State, Zip: _____

I REQUEST AND CONSENT THAT MY PROVIDER AT LABYRINTH PSYCHOLOGICAL SERVICES MAY CONTACT AND LEAVE MESSAGES WITH THE FOLLOWING PERSON(S) AS INDICATED:

Name: _____ Relationship: _____

Phone: _____-_____-_____ ☐ I designate this person as my emergency contact

☐ Leave detailed messages ☐ Leave callback information only

Name: _____ Relationship: _____

Phone: _____-_____-_____ ☐ I designate this person as my emergency contact

☐ Leave detailed messages ☐ Leave callback information only

I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken relying on this consent.

Signature of Patient/Guardian

Date

Revised 02/26/16