Lawrenceville Foot and Ankle Specialists
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HIPAA Consent to Leave Message and Discuss Medical Record

Patient name:____ Record Number: _________

I wish to be called at home ( ) or other ( ) , check all the apply, regarding my care and follow up, including appointments. The best telephone number(s) to reach me are:

Home:_________________________ Other: ____________________________

I do __, or Do not ___ (check one) give permission to leave relevant medical information on my answering machine or voicemail.

I do __, or Do not ___ (check one) want relevant medical information and/or billing information shared with the person who may call or answer the telephone. The name(s) of the individual(s) with whom you may discuss this pertinent information are:

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Patient Signature: __________________________________ Date: ________________