ELECTION AND CONSENT FOR PHYSICIAN-PATIENT COMMUNICATION

CRS/CCI may leave a voicemail message on the following numbers regarding the following:

______ Appointment/Procedure Information
______ Test Results
______ Instructions Regarding My Appointment

1. ______________________ Home/Work/Cell/Other (please circle)
2. ______________________ Home/Work/Cell/Other (please circle)
3. ______________________ Home/Work/Cell/Other (please circle)

CRS/CCI may speak to the following people regarding the following:

______ Appointment/Procedure Information
______ Test Results
______ Instructions Regarding My Appointment

1. ______________________
2. ______________________
3. ______________________

CRS/CCI may email me at:

____ with instructions regarding my appointment.

I understand that CRS/CCI does not and cannot guarantee the confidentiality of any voicemail messages or email communication and will not be liable for improper disclosure of confidential information and/or breaches in information caused by me or a third party.

I hereby voluntarily request and consent to communicate with my physician and/or office personnel via the above designated communication methods. I understand I still must sign a medical records release in order for CRS/CCI to release my health information to anyone.

________________________________	________________________	______________
Signature of Patient	Printed Name	Date

If patient is a minor, has a legal guardian, or a power of attorney exists:

________________________________	________________________	______________
Signature of Responsible Party	Printed Name	Date