Summit Medical Group
Consent for Healthcare Messages

Account # _____ DOB:____/____/____

I _____give permission to the physicians and their staff at

Summit Medical Group to leave messages regarding my healthcare in the following manner when I am not available. Please check the appropriate boxes to indicate your selections.

❑ May **ONLY** leave information with me and not anyone else. (If you check here, no other choices below should be marked).

❑ May leave appointment reminders on my answering machine/voice mail.

❑ May leave lab results on my answering machine/voice mail.

❑ May leave general questions/information on my answering machine/voice mail.

Please list your contact numbers and which is your preferred method to reach you.

❑ Home _____

❑ Cell _____

❑ Work _____

❑ Other _____

Please check what information we may share about you then list what person(s) can receive that information in the table following. **The person(s) you list will also be able to pick up prescriptions on your behalf if you are unable to.**

❑ May leave appointment reminders to be given to the following person(s).

❑ May leave lab results to be given to the following person(s).

❑ May leave general questions/information to be given to the following person(s).

❑ I prefer that all healthcare messages be given to the following person(s).

Name	Relationship	Phone Number

Advance Directive (Living Will/Power of Attorney):

Have you completed your Advance Directive? If so, does this office have a copy?

❑ Yes   ❑ No

Would you benefit from speaking with someone to help you complete your Advance directives?

❑ Yes   ❑ No

Patient or Guardian Signature _____ Date ____/____/____

Witness Signature _____ Date ____/____/____

SMG-1010/SDF,I.