Susan R. Tucker, M.D.

Patient Consent to Receive Telephone Messages

____

Please Print (Last Name) (First Name) (MI)

Do we have permission to:

Leave information on your answering machine/voice mail:

Home phone Y__ N__ Number________________

Cell Phone Y__ N__ Number________________

Communicate with any of your other physicians
Including drug and alcohol history Y__ N__

Communicate with any physicians you are referred to
Including drug and alcohol history Y__ N__

I give permission to share medical information with the following named person(s):

Name____

Name____

Name____

____

Patient Signature Date