FIRST PHYSICIANS GROUP
of Sarasota Memorial Health Care System

HIPAA/PATIENT CONTACT CONSENT

Patient (Last Name)	(First Name)	(M.I)	Date of Birth (MM/DD/YYYY)

I wish to be contacted in the following manner (please check all that apply):

☐ Home telephone: ( ) _____ - _____

☐ Work telephone: ( ) _____ - _____

☐ Cell phone: ( ) _____ - _____

May we mail a recall appointment reminder to your home? Yes _____ No _____

May we mail test results to your home? Yes _____ No _____

May we leave appointment information on your answering machine/voice mail? Yes _____ No _____

May we leave billing information on your answering machine/voice mail? Yes _____ No _____

May we leave medical information on your answering machine/voice mail? Yes _____ No _____

When available, would you like to be able to contact the office through secure electronic messaging via email? Yes _____ No _____

If yes, what is your email address: _____

I give permission to share appointment, billing or medical information with the following persons named below:

Appointment information: _____

Billing Information: _____

Medical information : _____

_____ _____

Signature of Patient / Parent or Legal Guardian Date

Revised 10/8/2014