TOTAL PATIENT CARE, LLC

HIPAA AUTHORIZATION

Patient Phone/Voice Mail Consent Form

Name _____ **Date of Birth**_____

Address _____

I hereby give my consent for Total Patient Care, LLC (the "Practice") to communicate with me by the communication method listed below unless I "opt out" now or in the future.

Telephone/Cell Phone. I hereby give my consent for the Practice to call me by phone at the phone number(s) provided below and to leave voice messages and/or to leave a message with the person answering the phone. These messages may be a reminder of my previously booked appointment date and time, or a notification that I need to make an appointment for a medication review, a payment reminder, or other message regarding care provided to me by the Practice.

I have requested that the Practice communicate with me via the method listed above as it is much more convenient for me to obtain updates and messages via such communication method. I acknowledge that the Practice does not have any obligation to provide any messages or updates to me via the communication methods listed above or by any other means in connection with appointment reminders or any other information.

I acknowledge that there is no assurance that any such voice message will be transmitted in a secure manner.

Numbers for calls/voice messages: Home:_____ **Cell:**_____

In addition to the above, the Practice may communicate / release my health information with/to the following persons:

Names of person/s that messages may be left with concerning any treatment:

Name: _____ **Addr:**_____ **Tel:**_____ **Rel:**_____

Name: _____ **Addr:**_____ **Tel:**_____ **Rel:**_____

Signed_____ **Date**_____

All patients have the right to change their minds and have this service stopped. If you no longer wish to receive these messages as set forth above, please notify the Practice in writing. If you change your mobile number or home number provided above number, please inform us so that we can update our records.