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	Time AM / PM

SARASOTA MEMORIAL HEALTH CARE SYSTEM
NEWTOWN INTERNAL MEDICINE
HIPAA / PATIENT CONTACT CONSENT
930285 Rev. 04/17

PLACE PATIENT ID LABEL HERE