



4809 Argonne Street
Suite 150
Denver, CO 80249
303.563.2784 (ph)
303.563.2781 (fax)

HOW CAN WE REACH YOU?

From time to time your provider will need to contact you. By filling out the information below we are better able to serve you.

I, _____ by filling in the spaces below give HealthONE my permission to speak with and/or leave a phone message regarding my medical care and/or billing information with the following individuals.

PLEASE CONSIDER CAREFULLY WHOM YOU AUTHORIZE TO HAVE ACCESS TO PROTECTED INFORMATION REGARDING YOUR CARE. I fully understand that this consent will remain valid until revoked in writing.

My Home answering machine# _____ Initials _____

My Cell or Cell voice mail: # _____ Initials _____

My Office/Work voice mail: # _____ Initials _____

My Spouse/Guardian **Name:** _____
_____ Initials _____

If other, please name: _____

Relationship to patient: _____
_____ Initials _____

In an effort to protect your privacy, we have developed a policy on leaving medical care message information.

- We will **NOT** leave messages with anyone except the patient or legal guardian unless stated above.
- We will **NOT** leave any confidential information on an answering machine unless stated above.
- We will **NOT** leave any messages on a voice mail unless stated above.

Signature _____ **Date** _____