Patient Name: _____

1330 Cesar E. Chavez Blvd, Portland, OR 97214
Phone: 503-232-1100 Fax: 503-232-7751 Web: www.cnmwellness.com

We consider patient confidentiality to be of utmost importance. In an effort to ensure your privacy is protected, please read and sign the following consent form.

AUTHORIZATION

I authorize my provider/clinic to leave a detailed message at the following phone number _____ regarding all below:
Please check all boxes that apply to you.

_____ Date and time of upcoming appointment
_____ Laboratory results (e.g., blood tests, Pap smear, urine or other cultures)
_____ X-ray, CT scan, MRI, or other radiological results
_____ Reminder to schedule recurring screening services or testing (e.g., mammogram, Pap, PSA, colonoscopy, annual health maintenance exam, etc)
_____ Referral information (appointment with another health care provider at an outside clinic)
_____ Any other information pertinent to my care
_____ Other (please list): _____

I understand that this authorization will remain in effect until such time that I submit, in writing, revocation of my authorization. I understand that by giving my consent, information about my personal health care could be made available to members of my family and/or others in my home who have access to my telephone messaging system.

Print Name: _____

Sign Name: _____ **Date:** _____/_____/_____

Witness: _____ **Date:** _____/_____/_____

NO AUTHORIZATION

I **DO NOT** authorize any messages related to my health care to be left on my voicemail/answering machine.

Print Name: _____

Sign Name: _____ **Date:** _____/_____/_____

Witness: _____ **Date:** _____/_____/_____

AUTHORIZATION REVOKED

Message authorization revoked on: _____/_____/_____
Initials of staff member receiving written revocation:_____