AMENDED_____

Patient Contact Consent Form

Dublin Primary Care
2685 Dublin Blvd.
Colorado Springs, CO 80918

Please Print Clearly

Patient Name: _____ Date of Birth: _____

Guardian/Parent Name: _____

In caring for our patients, it may be necessary for Dublin Primary Care to contact you by telephone. When you are not available to speak to directly, we like to leave messages when possible.

In Order to protect privacy, it is Dublin Primary Care's policy to:

- Not leave messages with anyone except the patient or legal guardian
- Not leave specific information on an answering machine/voice mail system.

Unless we have permission to do so
Please review the information below and consider carefully whom you chose to have access to your medical information, such as scheduling information, picking up prescriptions, about an upcoming procedure, inquiries about your insurance or billing information. Please check applicable ways for us to reach you/leave messages for you.

CONSENT:

Please check all that apply

___Home telephone or answering machine/voice mail (detailed message) #_____
___Office Telephone or office voice mail (detailed Message) # _____
___ Cell Phone (detailed message) # _____
___ Spouse (detailed message) Name: _____#_____
___ Mother (detailed message)Name: _____#_____
___ Father (detailed message) Name: _____#_____
___ Other: Name: _____#_____

If you have any questions please call Dublin Primary Care at (719) 592-9890
I have the option to update and/or change my preferences of how to contact me at anytime by completing a **NEW** PATIENT CONTACT CONSENT FORM or otherwise putting my request in writing and submitting it to Dublin Primary Care.

Patient/Guardian signature _____Date:_____

ONLY SIGN BELOW IF YOU ARE DENYING CONSENT TO BE CONTACTED

I, _____, wish to be contacted personally and **DO NOT AUTHORIZE** Dublin Primary Care to leave detailed messages with any other person or via answering machine/voice mail system.
Patient/Guardian signature _____Date:_____