Agreement to Receive Messages Containing PHI at Home

Name: _____

MRN: _____

I hereby authorize Dr. _____ or his / her designee to leave a message containing PHI necessary for my care

☐ On my answering machine at home or with anyone who answers my phone.

☐ At the following telephone number only.

Telephone Number: _____

Signature Patient: _____

Signature Personal Representative: _____

PRINT NAME: _____

Authority: _____

Date: _____

MR-225 (Rev 5 / 04)