dayton children's

Consent to Leave Voicemail Messages Containing Medical Information

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Dayton Children's staff will not leave voicemails containing your/your child's medical information without your consent. Complete this form if you wish for Dayton Children's staff to leave voicemails containing your/your child's medical information.

By signing this form, you consent to Dayton Children's leaving voicemails containing your/your child's medical information on the phone number(s) listed below. This information may include, but is not limited to, demographic information (patient name, date of birth, address, etc.), billing information, and medical information (appointment dates, diagnosis, medications, test results, etc.).

I, the undersigned, consent to voicemails containing my/my child's medical information at the following phone number(s):

Primary Phone: _____
(Area Code and Phone Number)

Alternate Phone (Optional): _____
(Area Code and Phone Number)

I understand that Dayton Children's cannot require me to sign this form in order to receive treatment. I understand that I am entitled to a copy of this completed form.

I understand that I have the right to revoke this consent at any time by sending a written request to Dayton Children's. My decision to revoke this consent does not apply to information disclosed in a voicemail prior to the date of revocation.

By my signature below, I certify that I have read and understood the items on this form, that I have given truthful information about my/my child's identity, and that I am either the patient or the patient's legally authorized representative.

Signed _____
Patient or Legal Guardian (if patient < 18 yrs)

Print Name _____

Date _____ Time _____