HIPAA CONSENT

CONSENT TO LEAVE MESSAGE

Patient Name: _____ Date: _____

(Print)

I wish to be called at home ___; other ____ (check all that apply) regarding my care and follow-up with Meridian Psychological Associates. The best telephone number(s) to reach me are:

_____ Home _____ Other

I do ___ I do not ____ give Meridian Psychological Associates and/or its Affiliates permission to leave relevant information regarding appointments, account information, etc. on my answering machine/voicemail.

I do ___ I do not ____ want relevant information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information such as appointment changes/confirmation, account information, etc. are:

_____ (Name and Relationship)

_____ (Name and Relationship)

_____ _____

Patient Signature Date

_____ _____

Witness Date