BEAR CREEK
MEDICAL PLAZA

1801 Hwy 99 North
Suite 2
Ashland OR 97520
PH 541.488.4464
FAX 541.488.3772

Patient Communication Consent

Patient Name_____

Address _____

Date of Birth _____/_____/_____

I consent that the following number(s) may be called and a message may be left on voice mail or in person with regard to any items that have to do with my health care, including laboratory and/or other test results.

The phone number(s) that I want calls to be made to is/are the following

Home # _____ **□ Yes □ No**

Cell # _____ **□ Yes □ No**

***I understand that by leaving information in this manner there is a chance that other people may have access to the information.**

I consent that I may be e-mailed with information regarding my health care, including laboratory and/or other test results.

□ Yes □ No

The e-mail address to which I would like things sent is _____

***I understand that e-mail may not be a secure means of transmittal.**

_____ _____
Signature of Patient **Date**

OR

_____ _____
Signature of Parent/Legal Guardian/Personal Representative of Patient **Date**