EDGE FAMILY MEDICINE
WELLNESS ADVANCED

COMMUNICATION CONSENT AGREEMENT

I understand that under the federal law Health Insurance Portability & Accountability Act of 1997, this medical office may not release any medical information to any individual without my expressed written permission. I therefore, give permission to Edge Family Medicine to release pertinent information on my behalf, in the following ways and to the following person(s), if any:

①

Consent to Leave Voice Mail Message - I understand that as part of my health care and treatment, Edge Family Medicine may need to reach me by phone. To provide effective care, I authorize Edge Family Medicine Providers and staff to **leave detailed messages regarding labs results, x-ray results, refills, prescriptions, treatment, etc. using a personal telephone number I have provided to be listed in my medical chart. This will allow me to hear of my results as quick as possible.**

***** If I change my contact telephone number, I will notify Edge Family Medicine as soon as possible using the patient portal, telephone, or in person. *****

I agree that If I am not contacted about my test results, I will call Edge Family Medicine and inquire about my results. No news DOES NOT mean good news, it may simply mean my provider did not receive the results. Ultimately, I, the patient, am responsible for following up on test results, referrals and prescribed medications.

②

I authorize Edge Family Medicine to Provide Information to:

☐ **Myself** **OR** ☐ **Myself and the person listed below**

Name: _____Relation to patient: _____
Address: _____ City _____State_____Zip Code_____
Phone (home) _____(mobile)_____ Birthdate: _____
Driver's License # (if known):

Patient Name: (print your complete name) _____

Edge Family Medicine will consider anyone given consent for communication able to receive medical information about the patient until notified otherwise by the patient.

③

Patient ID(circle) __ Driver's License / State Identification / Passport / Other: _____
(Identification must be non-expired)
Authorization Received By: _____ Date: _____

If applicable, revoke consent for (Name): _____
(This will **VOID** your prior consent form signed with Edge Family Medicine)
Date Effective: Immediately

I agree to sections 1, 2 and 3 as listed above.

Patient Signature: _____ Date: _____