CENTER OF SURGICAL EXCELLENCE

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Patient Consent to Receive Mail and/or Telephone Messages

Last Name First Name

Does Gastroenterology Associates of Venice & Englewood / Center of Surgical Excellence have permission to:

Send an appointment reminder to your home?	Yes	No
Send test results to your home?	Yes	No

Leave the following information on your home answering service:

Appointment information	Yes	No
Billing information	Yes	No
Medical information	Yes	No

Leave the following information on your work answering service:

Appointment information	Yes	No
Billing information	Yes	No
Medical information	Yes	No

My work/office number is: ( )_____-_____

I give permission to share appointment information with:

Name Relationship

I give permission to share medical information, including biopsy and lab results with:

Name Relationship

The person who is my Power of Attorney is:

Name Relationship

_____Date:_____
Signature of Patient