AMENDED_____

Patient Contact Consent Form

5410 Powers Center Pt. # 230
Colorado Springs, CO 80920
37 Widefield Blvd
Colorado Springs, Co 80911

Please Print Clearly

Patient Name:_____Date of Birth: _____

Guardian/Parent Name: _____

In caring for our patients, it may be necessary for Center Pointe Family Medicine to contact you by telephone. When you are not available to speak to directly, we like to leave messages when possible.

In Order to protect privacy, it is Center Pointe Family Medicines policy to:

- Not leave messages with anyone except the patient or legal guardian
- Not leave specific information on an answering machine/voice mail system.

Unless we have permission to do so

Please review the information below and consider carefully whom you chose to have access to your medical information, such as scheduling information, picking up prescriptions, about an upcoming procedure, inquiries about your insurance or billing information. Please check applicable ways for us to reach you/leave messages for you.

CONSENT:

Please check all that apply

___Home telephone or answering machine/voice mail (detailed message) #_____
___Office Telephone or office voice mail (detailed Message) # _____
___Cell Phone (detailed message) # _____
___Spouse (detailed message) Name:_____#_____
___Mother (detailed message) Name:_____#_____
___Father (detailed message) Name:_____#_____
___Other: Name:_____#_____

If you have any questions, please call Center Pointe Family Medicine at North (719) 282-6100 or the South location at (719) 390-4335

I have the option to update and/or change my preferences of how to contact me at any time by completing a **NEW** PATIENT CONTACT CONSENT FORM or otherwise putting my request in writing and submitting it to Center Pointe Family Medicine.

Patient/Guardian signature_____Date:_____

ONLY SIGN BELOW IF YOU ARE DENYING CONSENT TO BE CONTACTED

I,_____, wish to be contacted personally and **DO NOT AUTHORIZE** Center Pointe Family Medicine to leave detailed messages with any other person or via answering machine/voice mail system.

Patient/Guardian signature_____Date:_____