How Can We Reach You?

Your physician and other staff members will at times need to contact you. By filling out the information below, we will be better able to serve.

Name of Patient____________________________________ Date of Birth___________

Home/Evening Phone # ____

Work/Daytime Phone # ____

Cell/Other Phone # ____

Founders Family Medical Center and Urgent Care/KC Medical

In order to protect your privacy, we have developed a policy on leaving medical information.

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave any information on an answering machine.
- We will NOT leave any messages on a voice mail.

UNLESS

WE HAVE YOUR WRITTEN PERMISSION TO DO SO

Please read below and carefully consider whom you want to have access to your medical information.

I, ______________________________ give Founders Family Medicine my permission to leave a phone message regarding my medical care with the following. I fully understand that this consent will remain until revoked in writing.

My home answering machine: _____________Initials

My Cell Voice Mail: _____________Initials

My Office/Work Voice Mail: _____________Initials

My Spouse:________________________ _____________Initials

Other: _________________________________ _____________Initials

I acknowledge I completed this form and have received a copy of Founders Family Medical Center/KC Medical's Notice of Privacy Practices.

____ ________________

Signature Date