Patient Contact Consent Form
Dublin Primary Care
2685 Dublin Blvd.
Colorado Springs, CO 80918

Please Print Clearly

Patient Name: ________________________________ Date of Birth: ____________________

Guardian/Parent Name: ________________________________ ______________________________

In caring for our patients, it may be necessary for Dublin Primary Care 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 Dublin Primary Care’s 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 Dublin Primary Care at (719) 592-9890
I have the option to update and/or change my preferences of how to contact me at anytime by completing a NEW PATIENT CONTACT CONSENT FORM or otherwise putting my request in writing and submitting it to Dublin Primary Care.

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 Dublin Primary Care to leave detailed messages with any other person or via answering machine/voice mail system.

Patient/Guardian signature ___________________________________________ Date: __________