Brent C. Sigler, M.D.
Integrated Dermatology of Lone Tree, PLLC.

CONSENT TO LEAVE MESSAGES

Please choose one of the following:

_____I request **NO** messages be left on my phone numbers regarding my treatment, diagnosis, and/or care. I do understand that if we fail to reach you live on the phone, that our office will leave a message requesting that you call our office back.

OR

_____I agree that a message can be left with detailed health information regarding my treatment, follow-up, diagnosis, and/or care.

On what phone numbers may we leave a detailed message?

Phone Number: _____ Phone Number: _____

Who can we leave a message with?

Please choose one of the following

_____ I do **NOT** want my personal health information shared with anyone other than myself.

OR

_____I agree that the person listed below may receive detailed health information regarding my treatment, follow-up, diagnosis, and/or care.

Name: _____ Relationship to Patient: _____

This Consent was signed by: _____
Printed Name – Patient or Representative

X _____ __/__/__
Signature Date

Relationship to Patient
(if other than patient): _____