Crystal Lake Endodontics

610 Crystal Point Drive, Suite 6
Crystal Lake, IL 60014
(815) 455-9155

HIPAA Consent To Leave A Message

Patient Name: ____ Date: _____________________
(print)

I wish to be called at: (fill all that apply)

Home: ____

Cell: ____

Other: ____

Regarding my care and follow-up.

- ❑ I do
- ❑ I do not

Give permission to leave relevant medical information on my answering machine or voice mail. These might include: treatment plans, pre-medication reminders, and general Protected Health Information.

- ❑ I do
- ❑ I do not

Want relevant medical information to be shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave Protected Health Information are:

1. ____
2. ____
3. ____

____ ___________________

Patient Signature Date