ARLINGTON
PRIME PEDIATRICS

Voice Mail Release

Permission to Release Information Specific to Voice Mail In addition to the information contained within Arlington Prime Pediatrics, P.A. Acknowledgement of Privacy Practices, I give permission to Arlington Prime Pediatrics, P.A. office personnel to leave messages on my home answering machine and/or cell phone in regard to my/my child's routine and/or **NORMAL** laboratory and/or **NORMAL** radiology results.

I realize that I might not be the only person to hear such a message about me/my child:

☐ Yes, I give my permission to leave messages on my home answering machine and/or cell phone for reasons as stated above. (This permission is good for one year or until otherwise revoked by me)

_____
Home number for messages

_____
Cell phone number for messages

☐ No, do not leave messages about me/my child on my home answering machine and/or cell phone.

_____ _____
Patient name (please print) *Date of birth*

_____ _____
Signature of patient or patient's legally authorized representative *Date*

_____ _____
Printed name of authorized representative *Relationship to patient*

_____ _____
Witness *Date*