Date:___________________________

Name:____

Please initial all that apply:

__________I consent to receiving communication regarding my care via email.

__________I consent to have detailed messages left on my voicemail at home.

__________I consent to have detailed messages left on my cellular voicemail.

__________I consent to have detailed messages left on my voicemail at work.

__________I consent to have my care discussed with my spouse.

__________I consent to have my care discussed with my immediate family members.

__________I consent to have my care discussed with: _________________________.

__________I DO NOT want my care discussed with anyone other than myself.

By signing below you agree that you have been given the opportunity to review NFIMG's privacy practices. You may revoke your above designation(s) at any time via written request. Thank you for allowing our doctor's the opportunity to assist in your care.

Patient's Signature:____________________________ Date:__________________