

Eckert Wellness Center
Consent for Healthcare Messages

Account#: _____ DOB: __/__/__

I _____ give permission to the physicians and their staff at Eckert Wellness Center to leave messages regarding my healthcare in the following manner when I am not available. Please check the appropriate boxes to indicate your selections.

- May **ONLY** leave information with me and not anyone else. (If you check here, no other choices below should be marked).
- May leave appointment reminders on my answering machine/voice mail.
- May leave lab results on my answering machine/voice mail.
- May leave general questions/information on my answering machine/voice mail.

Please list your contact numbers and which is your preferred method to reach you.

- Home: _____
- Cell: _____
- Work: _____
- Other: _____

Please check what information we may share about you then list what person (s) can receive that information in the table following. **The person(s) you list will also be able to pick up prescriptions on your behalf if you are unable to.**

- May leave appointment reminders to be given to the following person(s).
- May leave lab results to be given to the following person(s).
- May leave general questions/information to be given to the following person(s).
- I prefer that all healthcare messages be given to the following person(s).

Name	Relation	Phone Number

Advance Directive (Living Will/Power of Attorney):

Have you completed your Advance Directive? If so, does this office have a copy?

- Yes No

Would you benefit from speaking with someone to help you complete your Advance directives?

- Yes No

Patient or Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____