Name/Practice Name

TELEPHONE APPOINTMENT REMINDER CONSENT

I ___________________________________ give ____

Patient Name (Print) Physician Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

□ Home _____________________________________

□ Work _____________________________________

□ Cell _____________________________________

Yes, this office may leave (check all that apply):

□ Voice mail at my Home □ Voice mail at my Work □ Voice mail on my Cell

□ Messages with people at my Home □ Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for alcohol dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

____________________________________ ___________

Patient Signature Date

____________________________________ ______________________________ __________

Parent/Guardian Signature Parent/Guardian Name (Print) Date

____________________________________ ______________________________ __________

Witness Signature Witness Name (Print) Date