PAUL M POPPER, MD, PA

PATIENT CONSENT TO RECEIVE MAIL AND/OR TELEPHONE MESSAGES

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_____

PRINT: (Last name) (M) (First name)

NAME AND BIRTHDATE OF SPOUSE: _____

DO WE HAVE PERMISSION TO:

SEND YEARLY APPOINTMENT CARD TO YOUR HOME? Y____ N____

SEND COPIES OF TESTS RESULTS TO YOUR HOME? Y____ N____

LEAVE ON YOUR HOME ANSWERING MACHINE REGARDING:

APPOINTMENT INFORMATION Y ____ N____

MEDICAL INFORMATION Y ____ N____

BILLING INFORMATION Y ____ N____

LEAVE ON VOICE MAIL AT YOUR PLACE OF EMPLOYMENT:

APPOINTMENT INFORMATION Y____ N____

MEDICAL INFORMATION Y____ N____

BILLING INFORMATION Y____ N____

I give permission to share appointment information with the person(s) listed below:

_____

I give permission to share ALL medical/testing information with the person(s) listed below:

_____

I give permission to share billing information with the person(s) listed below:

_____

Signature of Patient: _____ Date: _____