



North Fulton Internal Medicine Group, P.C.

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VOICEMAIL CONSENT

Date: _____

Name: _____

Date of Birth: _____

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: _____

OR

_____ 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: _____