

**Consent for Patient Contact
Platte Valley Medical Clinic**

Patient Name: _____
(Please print full name)

Designated Method of Contacting Patient

I hereby give my permission for any employee of the Platte Valley Medical Clinic to contact me through my:

(Please Check ALL that apply.)

Please provide at least 2 phone numbers that can be used to reach you.

Cell Phone Phone #: _____

Circle One: Leave detailed message

Leave call back only message

Leave detailed message with whomever answers phone: YES NO (**Please Circle**)

Home phone Phone #: _____

Circle One: Leave detailed message

Leave call back only message

Leave detailed message with whomever answers phone: YES NO (**Please Circle**)

Work phone and leave message to call back. Phone #: _____

Please list any other person below with whom we may leave a message:

Relative(s):

_____ Phone #: _____

_____ Phone #: _____

_____ Phone #: _____

Other:

_____ Phone #: _____

_____ Phone #: _____

Patient Signature: _____ Date: _____