



THE AUSTIN CENTER
FOR
RADIATION ONCOLOGY

1020 West 34th Street

PHONE MESSAGE CONSENT FORM

Your physician or other staff members may need to contact you. In an effort to protect your privacy, we have developed this consent form, which allows us to have clear way to notify you of your medical information.

Please be aware if you request a copy of your test results you will need to pick them up in person or it can be mailed to you be certified mail for a fee of \$5.00.

Please read below and consider carefully how you or any designated person will have access to you medical information.

Unless we have your written permission to do so, **we will not be able to:**

- 1. Leave any medical information on a voicemail or answering machine.**
- 2. Leave any medical information with anyone except the patient or legal guardian designated.**

I, _____ give The Austin Center for Radiation Oncology
Please Print Patient Name

Permission to leave phone messages regarding my medical care or information at the following phone numbers:

Home #: _____ Please Initial _____

Cell #: _____ Please Initial _____

Work #: _____ Please Initial _____

I, _____ give The Austin Center for Radiation Oncology
Please Print Patient Name

permission to discuss my medical care information with the following:

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

Name _____ Relationship _____ Phone # _____

I understand that my signature verifies that I have consented to all of the above information.
