Communication Consent

I give consent to Neuse Valley Internal Medicine to discuss my health information with the people listed below without limitations. As indicated, these individuals may also pick-up records/other paperwork or prescriptions/ medications on my behalf.

Name	Phone #	Relationship	Pickup Okay
_____	_____	_____	☐
_____	_____	_____	☐
_____	_____	_____	☐

Neuse Valley Internal Medicine will not leave sensitive information such as HIV and pregnancy test results, mental health, substance abuse information or any information that we feel should be communicated directly to you. In these instances, we may leave a message at your preferred phone number requesting that you return our call as soon as possible.

Below are two items which we have identified that that are not highly sensitive in nature. By giving us permission to leave a message, you will receive your information without delays. Please indicate your preference.

I give Neuse Valley Internal Medicine permission to leave test results and treatment information on my answering machine/voice mail at my preferred number.	YES	NO
I give Neuse Valley Internal Medicine permission to leave my PT/INR results and medication adjustment instructions on my answering machine/voice mail at my preferred number.	YES	NO

Requested Communication Restrictions

Neuse Valley Internal Medicine will make every effort to abide by any communication restrictions you may request. If applicable, please list communication restrictions below:

_____

_____

_____

I understand that it is my responsibility to update this information in writing if I wish to change any information in the communications consents or restrictions.

_____

(Printed name) (Signature) (Date)