CARITAS
CriticalCaseManagement

CONSENT TO LEAVE MESSAGE

At Caritas CCM LLC, we work to ensure the confidentiality regarding your Protected Health Information and care is maintained at all times. Due to confidentiality concerns and to comply with the HIPAA Act of 1996, we need your signature to allow us to leave messages about your upcoming office visit(s), account information, and/or any test results you may want us to convey to you via telephone or electronic messaging.

Please complete and sign this form, indicating your preference

I give Caritas Critical Case Management LLC permission to:

- Leave a message regarding my upcoming office visit, account information, and test results on my answering machine. Yes ☐ No ☐

- Leave a message at my home with someone who answers the phone at my residence. Yes ☐ No ☐

- Leave a message at my place of employment. Yes ☐ No ☐

This consent is signed by: _____

Patient Name: _____ Date: _____

Relationship (if other than patient): _____

Witness: _____
(Practice Representative)