Tennessee Reproductive Medicine, PLLC

Patient Agreement for Communications

I, _____, understand that as part of my health care Tennessee Reproductive Medicine, PLLC will need to contact me from time to time for the purposes of reminding me of an appointment, relaying the results of a test, advising me of special precautions and measures that I need to follow prior to a procedure, to follow-up after a procedure, etc. I hereby authorize Tennessee Reproductive Medicine, PLLC to contact me in the following ways:

_____ Home Phone (voice mail) Number: _____

_____ Office Phone (voice mail) Number: _____

_____ Cell Phone (voice mail) Number: _____

_____ Fax Number: _____

I authorize Tennessee Reproductive Medicine, PLLC to speak with the following person/s and release information on my behalf:

_____

_____

_____

I understand that Tennessee Reproductive Medicine, PLLC will use the minimum necessary information needed when they communicate with me indirectly. I understand that I can revoke or amend this agreement at any time. Any revocation or change will not apply to communications already complete.

Patient Name: _____ Date of Birth: _____

Patient ID: _____ SSN: _____

_____
Date

_____
Print Name

_____
Signature of Patient or Authorized Party

_____
Relationship to Patient