

Authorization for Use of Voice Mail

Declaration

I, _____ (name of patient), authorize Baptist Health to provide detailed information to me via my home and/or work or cell phone voice mail concerning appointment, referral and test information. I understand that I may revoke this authorization at any time.

Patient (Parent) Signature

Date

Time

**AUTHORIZATION FOR USE OF
VOICE MAIL**

Patient Name:

Date of Birth:

Medical Record #:

Financial #: