Kristine Eule, M.D.

Name: _____ Date of Birth: _____

HOW CAN WE REACH YOU?

Phone Message Consent

In effort to protect your privacy we have developed a policy on leaving medical care messages.

Please check one.

- ☐ Please do not leave a message with anyone except the patient or legal guardian.
- ☐ Please do not leave any confidential information on an answering machine.
- ☐ Please do not leave any message on a voicemail.
- ☐ Please leave any test result on my voice mail. (Patient Name must be on Voicemail)

UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

Please read below and consider carefully whom you authorize to have access to protected information regarding your care.

I, _____give Dr. Kristine Eule and/or one she designates, my permission to speak with and/or leave phone messages regarding my medical care, test results and or billing with the following.

I fully understand that this consent will remain valid until revoked in writing.

My HOME voice mail #: _____ Initials: _____

My CELL voice mail #: _____ Initials: _____

My OFFICE/WORK voice mail #: _____ Initials: _____

My spouse/guardian #: _____ Initials: _____

If other name: _____ Initials: _____

_____ _____

Signature: Date:

8200 E. Belleview Ave, Suite 414-C, Greenwood Village, CO 80111 O: 303-770-0665 F: 303-331-6171