Christian Health Care Center

Patient name _____

MR# _____

AUTHORIZATION TO CONTACT/LEAVE MESSAGES

I Authorize the Christian Health Care Counseling Center to call and confirm an appointment should the need arise. I understand that this is in no way a and/or designee breech of confidentiality and hereby grant permission for the Center to call and leave a message, if necessary, regarding the appointment. The Center will not release any information that is protected under state and federal guidelines, other than information about the appointment. I understand that I can revoke this authorization at any time by notifying the Christian Health Care Counseling Center in writing.

Please contact me at the following number(s):

Home_____

Cellular _____

Business_____

☐ I do not authorize the Christian Health Care Counseling Center **to contact me to confirm** my appointments.

SIGNED

_____ _____

Patient Date/Time

_____ _____

Parent/legal guardian Date/Time

_____ _____

Authorized counseling center representative Date/Time