VENICE DERMATOLOGY CLINIC, P.A.
Bruce A. Boyd, M.D.
716 The Rialto
Venice, FL 34285

Patient Consent to Receive Mail and/or Telephone Messages

_____
Please Print (Last Name) (First Name) (M.I.)

Do we have your permission to:

Send test results to you **Home** via mail/email. Yes _____ No _____

Leave the following information on your **Home** answering machine/voice mail/email.

Billing Information Yes _____ No_____
Medical Information Yes _____ No _____

Call you at **Work**? Yes _____ No _____

Leave the following information on your **Work** answering machine/voice mail/email.

Billing Information Yes _____ No_____
Medical Information Yes _____ No _____

I give my permission to share **medical** information with the person(s) named below:

Name: _____ Phone #: _____
Relationship: _____

I give my permission to share **medical** information with the person(s) named below:

Name: _____ Phone #: _____
Relationship: _____

_____ _____
Patient Signature Date