CARRBORO FAMILY MEDICINE CENTER, P.A.

Patient Centered. Community Based.

MEDICAL RELEASE TO LEAVE MESSAGE ON VOICE MAIL:

I _____give

Carroboro Family Medicine

Center permission to leave a voice mail on

_____Phone number.

I give permission for message's to be left concerning:

Please check all that apply:

Lab /pap results: _____

Radiology reports: _____

Appointment's: _____

Prescription's: _____

Medical advice: _____

Referral's: _____

Is there any information that you do not want left on voice mail?

Signature: _____

Print name: _____

Date: _____

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