



**Permission to Release Information Specific to Voice Mail**

In addition to the information contained within Cook Children's Physician Network (CCPN) Acknowledgement of Privacy Practices, I give permission to my CCPN physician's office personnel to leave messages on my home answering machine and/or cell phone in regard to my/my child's routine and/or NORMAL laboratory and/or NORMAL radiology results. I realize that I might not be the only person to hear such a message about me/my child:

**Yes**, I give my permission to leave messages on my home answering machine and/or cell phone for reasons as stated above. *(This permission is good for one year or until otherwise revoked by me)*

\_\_\_\_\_ **Home number** for messages

\_\_\_\_\_ **Cell phone number** for messages

**No**, do not leave messages about me/my child on my home answering machine and/or cell phone.

\_\_\_\_\_  
Patient name (please print)

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Signature of patient or patient's legally authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of authorized representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date