Midlands Medical Wellness Center, LLC
200 Springtree Dr, suite 200
Columbia, SC 29223
803-223-9328

PRIVACY ACKNOWLEDGEMENT FORM

I hereby acknowledge receipt of the Midlands Medical Wellness Center, LLC notice of Privacy Practices and have been provided with opportunity to review it.

_____

Patient's name date of birth

_____

Patient's signature date

PATIENT CONSENT TO LEAVE DETAILED MESSAGE/INFORMATION

Midlands Medical Wellness Center, LLC requires our staff to obtain prior authorization to leave detailed voicemail/email/messages for the patient. This policy is to protect the patient and also our staff from violating the patient's confidentiality. If we do not have a signed consent form on file, the staff may leave only their name and a phone number on an answering machine/voicemail asking you to call them back.

By completing the consent below, you hereby authorize the staff to call and leave their name, doctor's name, and additional information on an answering machine/voicemail or with a specific individual. Unless notified in writing, this consent will remain in effect permanently.

I give my consent to Midlands Medical Wellness Center, LLC to leave message regarding treatment, test results or other necessary information.

1.) on home phone_____

2.) on work phone_____

3.) on cell phone_____

4.) on email_____

_____

Patient's Signature Date

I DO NOT consent to any messages being left on answering machine/voicemail other than caller's name and phone number.

_____

Patient's Signature Date