

Rhoda Estrella-Itchon, MD, Inc.

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AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

Patient's Name: _____
(Please Print)

I hereby give permission for Dr. Rhoda Estrella-Itchon to leave messages regarding office visits, surgery information and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s) and/or with the following individual(s):

(Please check all that apply)

Home Answering Machine Phone Number: _____

Family Members *(Please list below)*

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Housekeeper *(Please list below)*

Name: _____ Phone Number: _____

Work Voicemail Phone Number: _____

Assistant *(Please list below)*

Name: _____ Phone Number: _____

Other *(Please list below)* Phone Number: _____

 I DO NOT give my permission to Dr. Rhoda Estrella-Itchon to leave any medical information related to my condition to anyone other than myself in a direct manner. Please call me at the following phone number: _____

Signature

Date

Relationship: Self
 Parent or Legal Guardian
 Other: _____