



Mount Auburn Breast Center

of The Tisch Cancer Institute

Sign

Agreement to Receive Messages Containing PHI at Home

Name

MRN

I hereby authorized Dr. _____ or his/her designee to leave a message containing PHI necessary for my care.

On my answering machine at home or with an individual who answers my phone.

At the following telephone number only:

Telephone Number:

Signature Patient

Print Name

Signature Personal Representative

Print Name

Authorit

Date