

**Virginia Center for Medicine**

43490 Yukon Dr. #210

Ashburn, VA 20147

(703) 726-2566

**Authorization to Leave Telephone Message**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I authorize the office of Dr. Harneet Kohli to leave voice mail messages at the following number(s). Messages at time may include some protected health information, including appointment reminders, test results and instructions. I understand that with my signature, I am authorizing the release of oral communication by the office of Dr. Harneet Kohli to the following number(s):

Home: \_\_\_\_\_

Office: \_\_\_\_\_

Cell: \_\_\_\_\_

I have been advised to call Dr. Kohli's office if I have not received my test results in a week of getting the tests. In case of abnormal results, I may be required to make a follow up appointment.

**\*This authorization is valid until I revoke it in writing. It is my responsibility to notify the office of any changes in my contact information.\***

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_