J. DOUGLAS CUSICK, M.D., F.A.C.S., Inc.
BOARD CERTIFIED
Plastic, Cosmetic, Reconstructive
and Hand Surgery

Patient Consent to Leave Detailed Message/Information

Dear Patient:

J. Douglas Cusick, M.D., F.A.C.S., Inc. has adopted a policy that requires our staff to obtain authorization from the patient to leave detailed messages for the patient. This policy is to protect the patient and to protect our office staff from violating the patient's confidentiality. If we do not have a signed consent on file, the staff may only leave their name and a phone number on an answering machine asking you to call them back.

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

I give my consent to J. Douglas Cusick, M.D. and/or his staff, to leave a message regarding treatment, test results, or other information as necessary.

_____ _____

Patient Signature **Date**

Patient Refusal of Consent to Leave Message/Information

I refuse to give consent as stated above and, therefore, accept full responsibility to call my physician or his staff on a timely basis to receive results of any tests and/or exams that were performed. I understand that if the physician or office staff does call, they will leave a first name only and a request that I return the call, placing the responsibility for the outcome of my medical care fully upon me.

_____ _____

Patient Signature **Date**

Member
AMERICAN SOCIETY OF PLASTIC SURGEONS

4601 College Blvd., Suite 222 • Leawood, KS 66211 • (913) 661-0202 • 1(877) 661-0202 • Fax (913) 661-0584