James W. Marsh, M.D., P.A.
PLASTIC AND RECONSTRUCTIVE SURGERY

2677 SOUTH TAMIAMI TRAIL
SARASOTA, FLORIDA 34239
TELEPHONE (941) 366-9818

PATIENT CONSENT TO RECEIVE MAIL and/or TELEPHONE MESSAGES

Patient Name: _____
PLEASE PRINT

Do we have your permission to:

Call you/send mail to you at **home**? Y ____ N ____
If Yes, may we leave the following information on your **home** answering machine/voice mail:
Appointment information Y ____ N ____
Billing information Y ____ N ____

Call you at **work**? Y ____ N ____
If Yes, may we leave the following information on you **work** answering machine/voice mail:
Appointment information Y ____ N ____
Billing information Y ____ N ____

I give my permission to share **appointment** information with the person(s) listed below:

Name: _____

Relationship: _____

I give my permission to share **billing** information with the person(s) listed below:

Name: _____

Relationship: _____

X _____ _____
PATIENT SIGNATURE DATE

SM