SHERBONDY'S
PSYCHIATRIC SERVICES
225 Adley – Greenville, SC 29607
Ph # (864)987-9747 – Fax # (864) 987-9770

TELEPHONE APPOINTMENT REMINDER/ EMAIL CORRESPONDENCE CONSENT

I, _____ give _____
Patient Name (Print) Physician Name (Print)

And members of his/her staff working at the location indicated above and or automative phone system, my permission to call me prior to an appointment to remind me of appointment date and time.

I would prefer to be called at (check all that apply)
□*Home:* _____
□Work: _____
□Cell: _____

Yes, this office may leave (check all that apply)

□Voice mail at my Home
□Messages with people at my Home
□Voice mail on my Cell
□Voice mail at my work
□Message with people at my work
□**Email Correspondence**

I understand that I may withdraw this consent at anytime, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last if / while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

_____ _____ _____
Signature of Patient (or Patient's Legal Representative) Patient Name **(PRINT)** Date

_____ _____ _____
Witness Signature Witness Name **(PRINT)** Date

UPDATED 9/2012