Aman Mongia, M.D.
Anu Mongia, M.D.
100 Market Place Blvd, Suite 207
Cartersville, GA 30121-8716

MESSAGE CONSENT FORM

(Please Read and Sign Message Consent)

I,_______________________________________ give **Aman Mongia, M.D./Anu Mongia and**
(Please Print: Your First and Last Names)
their staff permission to leave a message or speak with the following people regarding my test results, appointments, messages, etc.

Please list below anyone with whom **We** can speak on your behalf. **We shall not** give any information to anyone not listed on this Message Consent Form.

NAME:	TELEPHONE NUMBER	RELATIONSHIP

If you are not home, may **We** leave a message on your answering machine. (Please check)

YES ________ NO ________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_______________________________________ _______________________
Patient (or Responsible Party) Signature **Date**