



# Cognitive Aging Research and Education Center

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## CONSENT FOR COMMUNICATION VIA VOICEMAIL

I, \_\_\_\_\_ (*patient name*), hereby consent to have members of the Cognitive Aging Research and Education (CARE) Center treatment team (including students who are involved in my care) leave specific information regarding my care (e.g., appointment scheduling/confirmations, information about prescriptions or medical/lab test orders or results, updates on medical records requests), on my voicemail at \_\_\_\_\_ (*phone number*).

I understand that voicemail is not a confidential method of communication. I further understand that there is a risk that voicemail communications between my CARE Center treatment team and me may be intercepted by third parties or transmitted to unintended parties.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Legal Representative

\_\_\_\_\_  
Relationship to Patient  
(if Legal Representative)