Aslam Loya, M.D., F.A.C.P. **Coastal Medical Group** **Munir Loya, M.D., F.A.C.P.**
11920 Astoria Blvd, Suite 110
281-464-8484

Patient Authorization To Leave Recorded Messages

Patient Name: _____ D.O.B.: _____
(Please Print)

I hereby give permission for the office of Coastal Medical Group to leave messages regarding office visits, appointment confirmations and payment options, as well as any medical information related to my treatment at the following phone number(s) and/or the following individual(s):

(Please check all that apply below)

___ Home Answering Machine Phone Number: _____

___ Family Members (Please list below)
Name:_____ Phone Number: _____
Name:_____ Phone Number: _____
Name:_____ Phone Number: _____

___ Work Voicemail Phone Number: _____
Extension #: _____

___ Other (Please list below) **I am fully aware that a cell phone is not a secure & private line**
Name:_____ Phone Number: _____

___ I DO NOT give my permission for the office of Coastal Medical Group to leave any medical information related to my condition to anyone other than me in a direct manner. Please call me at the following telephone number: _____

_____ _____
Signature **Date**