Weill Cornell Medicine
Ronald O. Perelman and Claudia Cohen
Center for Reproductive Medicine

NewYork-Presbyterian

Patient Information

Patient Name: _____ Date of Birth: _____

Authorization for Voicemail Messages

At the Ronald O. Perelman and Claudia Cohen Center for Reproductive Medicine (CRM), I understand that my treatment requires that I receive telephone calls from the CRM team. I understand that an attempt will be made to contact me directly at the telephone number(s) provided below. I hereby authorize the CRM team to leave a message at the telephone number(s) provided below.

I understand this authorization is valid until I revoke it. I understand that I can revoke this authorization at any time by filling out and submitting a Revocation of Voicemail Message Form, which I can obtain at this office upon request.

Please leave a message for me at the following telephone number(s):

(1) _____ (2) _____

CRM may leave a message regarding the following:
Medication protocol, stimulation instructions, lab results (non-HIV results), pregnancy results, appointments

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Pharmacy Information

Please provide the details for your preferred local and specialty pharmacies:
(1) Pharmacy Name: _____ Phone Number: _____
Address: _____

(2) Pharmacy Name: _____ Phone Number: _____
Address: _____

Authorization for Email Correspondence and Acknowledgement of Email Correspondence Limitations

I understand and acknowledge that email is not an emergency means of correspondence, and that the CRM team may not respond to an email expeditiously.

I understand and acknowledge that, if I have bleeding, pain, or any other symptoms of a non-routine nature, calling the doctor-on-call (646-962-2764) or 911 is a more appropriate means of communication.

I understand and acknowledge that by communicating with my physician or my physician's office by email, I have thereby authorized email communication to me from my physician and my physician's office. I understand this authorization is valid until I revoke it. I may revoke such authorization, at any time, by filling out and submitting a Revocation of Email Message Form, which I can obtain at this office upon request.

Email address: _____

Patient Signature: _____ **Date:** _____