

**Agreement to Receive Messages Containing Protected Health Information**

**Name:** \_\_\_\_\_

I hereby authorize the World Trade Center Medical Monitoring Program to leave a message containing Personal Health Information necessary for my care.

- On my answering machine at home or with anyone who answers my phone.
- At the following telephone number only: \_\_\_\_\_

Signature Patient: \_\_\_\_\_

Signature Personal Representative: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_

Date: \_\_\_\_\_

MR-225 (Rev 5/04)

**Please return this completed form by faxing it to (212) 241-1850 or by mailing it to WTC Medical Monitoring Program, Mount Sinai Medical Center, One Gustave L. Levy Place, Box 1057, New York NY 10029.**