



Authorization to Leave Personal Health Information
By Alternative Means

Patient Name: last first middle Date of Birth: mm/dd/yyyy

May leave detailed message on:

Home Voicemail: () -
Work Voicemail: () -
Cell Phone: () -
Other: () -

Preferred number to be reached during business hours: Home Work Cell Other

May discuss my healthcare with:

Spouse/Partner: () - Name:
Other: () - Name:

With my signature below, I acknowledge and understand that this information will be kept in my medical record and will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Signature: Patient or legally authorized individual Date