



**Authorization to Leave Personal Health Information
By Alternative Means**

Patient Name: _____ **Date of Birth:** _____
last first middle 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: _____ Date _____
Patient or legally authorized individual