

## AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE 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 LEAVE INFORMATION 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