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**AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY
ALTERNATE MEANS**

Patient Name: _____ DOB: _____

(Please check all that apply):

- May leave detailed message on voicemail at home # _____
- May leave detailed message on voicemail at work # _____
- May leave detailed message on cell phone #: _____
- May leave detailed message on different phone #: _____
- May leave detailed message with family member(s)
(names): _____
at the following phone #: _____
- May correspond via email (email address): _____
- DO NOT leave any detailed message on phone or email**

Please note that "detailed message" includes lab/test results.

With my signature below, I acknowledge and understand that this information will be kept in my medical record, and the above parameters will be followed 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.

I also acknowledge that with the authorization of messages on voicemail, other people in my household may hear the personal health information left on the voicemail message.

Patient or Legally Authorized Signature

Date