PROLIANCE SURGEONS®

Authorization to Leave Personal Health Information By Alternate Means

Patient Name: _____ **Date of Birth:** _____

Patient Mailing Address: _____

_____

(Please check all that apply)

☐ May leave detailed message on voicemail at home # : (__)_____

☐ May leave detailed message on voicemail at work # : (__)_____

☐ May leave information with spouse (name) : _____

☐ May leave information with other family member: _____

☐ May leave detailed message on cellular phone # : (__)_____

☐ May leave detailed message at a different location # : (__)_____

☐ May send detailed message by email to: _____

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

Patient or legally authorized individual signature Date

Last Update: 2/11/2004