



Authorization to Leave Personal Health Information By Alternate Means

Date: _____

Name: _____

Date of Birth: _____

Authorization

I hereby authorize Medford Women's Clinic to leave detailed, personal health information by the following means: (please initial all that apply)

___ Voicemail message on my home phone(number)_____

___ Voicemail message on my work phone (number)_____

___ Voicemail message on my cell phone (number)_____

___ Voicemail message at a different location (number)_____

___ Verbal message with spouse/partner/SO (name)_____

___ Verbal message with family member (name/relationship & number)_____

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

 Signature of patient or legally authorized agent

 Date signed

Patient Rep(initials):_____ Date:_____

Patient update(initials):_____ Date:_____ Patient Rep (initials):_____ Date:_____