Authorization to leave Personal Health Information By Alternate Means

Please check all that apply

_____May leave detailed message on voice mail at home
_____May leave detailed message on voice mail at work
_____May leave appointment information with spouse
_____May leave appointment information with another family member_____
_____May leave detailed message on cellular phone #(___)_____
_____May leave message at a different location (__)_____

Request for Limitations & Restrictions of Protected Health Information

Please note: The practice is not required to agree to your request. Please see our *Notice of Private Practices* for more information regarding such requests.

Please check all that apply

_____Do not call home phone number, use: (_____)_____
_____Do not use home address, use:_____
_____Do not call me at work
_____Do not release Medical Records to any of my other medical providers
_____Do not release information to spouse_____
_____Do not release information to another family member_____
_____Other:_____

Patient Name: _____

Patient Signature:_____Date:_____

Staff Witness:_____

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