Authorization to Leave Personal Health Information by Alternate Means

Patient Name: ____ Today's Date: ______________ Date of Birth: ______________

Please check all that apply:

My cell phone number: _____________________________

OK to call me with test results

OK to leave a message with test results if normal and I don't answer

My email address: _________________________________

OK to release results via secure email

Preferred method of contact: Cell Email

OK to talk to the following people about ____

Parent: Name: ______________________________ Relationship: _____________________ Phone #: ______________

Other Caregiver: Name: ______________________ Relationship: _____________________ Phone #: ______________

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.

____ _______________________________

Signature of Patient Date

By typing your name in the signature field, you confirm that the information provided above is accurate to the best of your knowledge and authorize disclosure of the requested information.

This authorization will expire in 90 days. If you wish to shorten or extend this time, please enter an alternate expiration date below.

Expiration Date: ________________________