AUTHORIZATION TO LEAVE HEALTH INFORMATION BY ALTERNATE MEANS

Patient Identification

Name: ____
First Middle Last

Date of Birth: _____________________________________
Month/Day/Year

Authorization

I hereby authorize The Charis Clinic PLLC to leave detailed, personal health information by the following means: (please complete all that apply)

□ Voicemail message at my home number: _____________________________________
(area code and number)

□ Voicemail message at my work number: _____________________________________
(area code and number)

□ Voicemail message on my cellular phone: _____________________________________
(area code and number)

□ Voicemail message at a different location: _____________________________________
(area code and number)

□ Verbal message with my spouse or partner: _____________________________________
(NAME, area code and number)

□ Verbal message with other family member: _____________________________________
(NAME, area code and number

□ Email message: ____
(include BEST email address, note that email is unsecured)

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 The Charis Clinic PLLC in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

____ _____________________________________
Signature of Patient or Legally Authorized Representative Date Signed