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: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Voicemail message at my work number: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Voicemail message on my cellular phone: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Voicemail message at a different location: _____☐ Check if Preferred Method of Contact
(area code and number)

☐ Verbal message with my spouse or partner: _____☐ Check if Preferred Method of Contact
(NAME, area code and number)

☐ Verbal message with other family member: _____☐ Check if Preferred Method of Contact
(NAME, area code and number)

☐ Secured email/portal messages: _____
Note that we do not use unsecured email

☐ **I hereby authorize access to my own personal health record** (an enrollment email will be sent to you and the clinic will give you a PIN so that you can access your record). This is available to adult clients.

I also authorize the exchange between the Electronic Health Record and state Immunization Registry.

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--Page 1 of 1--