genesis
pediatric medicine

Authorization to Leave Personal Health Information by Alternate Means

Patient Name _____ Date of Birth _____

Patient Mailing Address _____

Please check all that apply.

We:

☐ May leave a detailed message on your home voicemail.

☐ May leave a detailed message on your work voicemail.

☐ May leave information with your spouse: _____.
Name & number

☐ May leave information with another family member: _____.
Name & number

☐ May leave a detailed message on your cellular phone.

☐ May send automated text messages for appointment reminders and scheduling.

☐ May leave a detailed message at a different phone number: _____.
Name & number

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.

Patient or legally authorized individual's signature _____ Date _____

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