

MINOR & JAMES MEDICAL, PLLC

Authorization to Leave Personal Health Information by Alternate Means

Patient Name: _____ D.O.B.: _____

Patient Address: _____

(Please check all that apply)

- May leave detailed message on voicemail at home #: _____
- May leave detailed message on voicemail at work #: _____
- May leave information with spouse (name): _____
- May leave information with other family member: _____
- May leave detailed message on cellular phone #: _____
- May leave detailed message at a different location #: _____

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

For Clinic Purposes Only:

1. Form must be on yellow paper.
2. File in the advanced directive section of medical record.
3. For patient authorized revocation use the *Revocation of Authorization for Minor & James to Use or Disclose Health Care Information* form (MJ -- 0294).