The Seattle Arthritis Clinic

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

(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 (name):_____

May leave detailed message on mobile phone #:_____

May leave detailed message on different phone #:_____

May correspond via email (email address):_____

DO NOT leave any detailed message on phone or email

Please note that detailed message includes lab/test results.

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 signature Date

Patient Name:_____DOB:_____

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