OBSTETRIX MEDICAL GROUP

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____Date of Birth_____
Last First mm/dd/yy

(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 (please name):_____

___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 on or more of the telephone numbers listed above.

Patient or legally authorized individual signature:_____Date_____

Preferred Pharmacy :

Please fill out as much as you can!

Name of Pharmacy: _____

Location: _____

Phone: _____ Fax: _____