



## The Seattle Arthritis Clinic

### AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Patient Mailing 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 (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