

**Authorization to Leave Personal Health Information by Alternate Means**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

**May leave a detailed message on voicemail:**

Home: (\_\_\_\_\_) \_\_\_\_\_

Cell: (\_\_\_\_\_) \_\_\_\_\_

**May leave a detailed message on voicemail at work:** (\_\_\_\_\_) \_\_\_\_\_

**May leave detailed information with emergency contact(s):**

**Name:** \_\_\_\_\_

*Relationship to Patient:* \_\_\_\_\_

*Number:* (\_\_\_\_\_) \_\_\_\_\_

**Name:** \_\_\_\_\_

*Relationship to Patient:* \_\_\_\_\_

*Alternate Number:* (\_\_\_\_\_) \_\_\_\_\_

With my signature below, I acknowledge and understand that this information will be kept in my confidential medical record and the 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 Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Name of Legally Authorized Individual (printed)

\_\_\_\_\_  
Relationship to Patient

PLACE PATIENT LABEL HERE

**UW Medicine**  
Harborview Medical Center – University of Washington Medical Center  
UW Neighborhood Clinics – Valley Medical Center  
University of Washington Physicians Seattle, Washington

**AUTHORIZATION TO LEAVE PHI**

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WHITE - MEDICAL RECORD