

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