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# Swedish Urology Group, PC

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## Authorization to Leave Health Information by Alternate Means

### Patient Identification

Name: _____
First Middle Last

Date of Birth: _____
Month/Day/Year

### Authorization

I hereby authorize Swedish Urology Group, PC to leave detailed, personal health information by the following means: (please complete all that apply)

- ☐ Voicemail message at my home number: _____
  area code and number
- ☐ Voicemail message at my work number: _____
  area code and number
- ☐ Voicemail message on my cellular phone: _____
  area code and number
- ☐ Voicemail message at a different location: _____
  area code and number
- ☐ Verbal message with my spouse / SO: _____ _____ _____
  Name area code and number
- ☐ Verbal message with other family member: _____ _____ _____
  Name area code and number

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more of the telephone numbers and/or contacts listed above.

_____ _____
Signature of Patient or Legally Authorized Representative Date Signed