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

This authorization form can be faxed to us (preferred) or sent by postal mail.

Fax: 920-214-1187 Phone: (920) 882-7780 (call if you have questions)

Mail
Attn: Medical Records
Fox Valley Psychiatry Ltd.
4321 W College Ave, Ste 200, Appleton, WI 54914

fox valley
PSYCHIATRY
2024