SPECTRUM INTERNAL MEDICINE

401 South Main Street, Suite C7, Alpharetta, GA 30009. Tel.: 678-319-9901, Fax: 678-319-9902

Authorization to leave Personal Health Information by Alternate Means

(This excludes the following information regarding testing, diagnosis, and/or treatment for HIV(AIDS virus), sexually transmitted diseases, psychiatric disorder/ mental health, or drug and/or alcohol use.)

Patient Name:_____ Date of Birth_____

(Please fill in all spaces that apply)

May leave detailed message on home voicemail#_____

May leave detailed message on work voicemail#_____

May leave detailed message on Personal cell voicemail#_____

May leave detailed message on spouse's cell voicemail (Name & Telephone number)_(name)_____(Tel. #)_____

May leave detailed with family member (name)_____

May leave detailed message at different location#_____

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

Patient or legally authorized Person:

_____ _____ _____

Signature **Patient or legally authorized Name** **Date**

Updated 05/2014