OPA ORTHO
ORTHOPEDIC PHYSICIAN ASSOCIATES

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

PATIENT NAME: _____ DATE OF BIRTH: _____
LAST FIRST MIDDLE MM/DD/YYYY

MAY LEAVE DETAILED MESSAGE ON:

HOME VOICEMAIL: (_____) _____ - _____

WORK VOICEMAIL: (_____) _____ - _____

CELL PHONE: (_____) _____ - _____

OTHER: (_____) _____ - _____

Preferred number to be reached during business hours: ☐ **Home** ☐ **Work** ☐ **Cell** ☐ **Other**

MAY LEAVE INFORMATION WITH:

SPOUSE/PARTNER: (_____) _____ - _____ NAME: _____

OTHER: (_____) _____ - _____ NAME: _____

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

SIGNATURE _____ DATE _____
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL