SEATTLE NEURO AND SPINE SURGERY

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

OVER →

PROLIANCE SURGEONS®

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose the medical information that we maintain about you. It also explains how you can access this information. By signing, you acknowledge that you have reviewed the Notice of Privacy Practices of Proliance Surgeons, Inc., P.S.

_____ _____

Signature of Patient or Guardian Date Time

_____

Printed Name

Effective: April 14, 2003 (Revised: September 23, 2013)