AUI Authorization for disclosure and secondary contact(s):

Patient Name: _____ DOB: _____

Signature: _____ Date: _____

From time to time, in caring for our patients it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave detailed phone messages (for example, lab results) when possible. There are also times where you may want us to communicate labs, medication, treatment plans, appointments, or billing information to a trusted family member. In order to protect your privacy, we need your written permission to leave detailed phone messages on your voicemail, answering machine or communicate with a family member or friend.

☐ **I do consent…** **or** ☐ **I do NOT consent …**

…for my healthcare provider or representative to leave detailed phone messages and/or discuss my medical information and/or appointments including my personal health information (PHI) with the following person(s) listed below. This will remain in effect until you state otherwise in writing.

Your own preferred phone number: _____

Names of family members or other people we may contact about you (please indicate relationship of person to you). Leave it blank if you do NOT want us to be able to talk to anyone or share information.

Name :_____
Relation to you:_____ Phone #:_____

Name :_____
Relation to you:_____ Phone #:_____

Name :_____
Relation to you:_____ Phone #:_____