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ALTERNATIVE CONTACTS FORM

We at **ARK-LA-TEX SPINE CARE** take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls, or you have an adult member that helps coordinate your medical care. **You should not designate your doctor, attorney, or nurse case manager.**

As part of our Patient Privacy Policy, we will not leave health information with any other person(s) unless you specifically authorize below.

_____ I do not authorize anyone to receive information regarding my medical care

_____ I do authorize my physician and employees of this clinic to speak with:

1. Person: _____ Phone Number(s): _____

Relation to Patient _____

❑ Appointments ❑ Account/Bill ❑ MRI/Lab Results ❑ Medical Care

2. Person: _____ Phone Number(s): _____

Relation to Patient _____

❑ Appointments ❑ Account/Bill ❑ MRI/Lab Results ❑ Medical Care

3. Person: _____ Phone Number(s): _____

Relation to Patient _____

❑ Appointments ❑ Account/Bill ❑ MRI/Lab Results ❑ Medical Care

This authorization will remain in effect unless changed by me while I am a patient at this office. It is my responsibility to notify this office of changes and to complete a new form.
I agree that should I desire to revoke this authorization or make changes, I will give written notice.

Patient Name: _____ Date of Birth: _____

Patient Signature: _____

Witness Signature: _____

Today's Date: _____