Alliance HEALTH

Authorization For Communication of Protected Health Information Via Telephone Messages

____

Patient Name (Please Print)

has authorized that confidential protected health information, specifically the results of medical tests, can be left as telephone messages at either of the telephone numbers listed below.

___(________)________________________

___(________)________________________

Patient Signature __________________________________ Date ___________________

\- - - - - - - - - - - - - - -

Request for Confidential Communication of Protected Health Information

____

Patient Name (Please Print)

Has requested that confidential communication of their protected health information may be directed to :

Name:____ Relationship: __________________

Address:______________________________ City:_______________ State:_____ Zip:_______

Phone:____________________

Patient Signature __________________________________ Date ___________________