O L Y M P U S C L I N I C

4624 HOLLADAY BOULEVARD SLC, UT 84117 PHONE (801) 277-2682

AUTHORIZATION TO LEAVE PERSONAL HEALTH & BILLING INFORMATION BY ALTERNATE MEANS

Date: _____

We want to stay in touch with you regarding your account, concerning your medical information as well as your billing information. By signing this form you are authorizing us to contact you through the following selected communication options:

(Please check all that apply)

☐ May leave detailed message on voicemail at home phone #: (_____)_____

☐ May leave detailed message on voicemail at work phone #: (_____)_____

☐ May leave detailed message on voicemail at cell phone #: (_____)_____

☐ May leave information with spouse: _____
Spouse's Name

☐ May leave information with other family member:

_____
Family Member's Name Relationship to Patient

With my signature below, I acknowledge and understand that this form will be kept in my medical record and the above parameter 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.

_____
Patient's Name (Please Print) Patient's DOB

_____
Signature of Patient or Patient's Legal Guardian Relationship to Patient