BREAST CARE SPECIALISTS AMC

CHRISTOPHER S. SOCKRIDER, MD, FACS & JULIE MOOK BROADWELL, MD, FACS

AUTHORIZATION OF ALTERNATE CONTACTS

This authorization form, when completed and signed by you, allows our staff members to speak only with an individual(s) your designate in the event that you are not available to receive our phone calls or you have an adult family member that helps coordinate your medical care. **You should not designate a physician.**

If you feel, for example, comfortable allowing us to talk with another person regarding an appointment, you would want to check that box. Please check all the boxes that apply to your needs. If there is another person you wish to authorize, please complete the next sections as you did the first.

( ) I do not authorize anyone to receive information regarding any medical care.
This means that we cannot give information to a spouse, child or parent.

I authorize the following individual(s):

____
Name

____
Phone #

______Appointment
______Account/Bill
______Lab Results
______Test Results
______Medical Care

____
Name

____
Phone #

______Appointment
______Account/Bill
______Lab Results
______Test Results
______Medical Care

____
Name

____
Phone #

______Appointment
______Account/Bill
______Lab Results
______Test Results
______Medical Care

____
Name

____
Phone #

______Appointment
______Account/Bill
______Lab Results
______Test Results
______Medical Care

( ) Home Telephone ________________
( ) OK to leave message with detailed information
( ) Leave message with call-back number only

( ) Work Telephone ________________
( ) OK to leave message with detailed information
( ) Leave message with call-back number only

( ) Written Communication
( ) OK to mail to home
( ) OK to mail to work/office
( ) OK to fax to ___________________

( ) Other ________________
____

____
Patient's Name (Please Print)

____
Date

____
Patient's Signature