BREAST CARE SPECIALISTS AMC
AUTHORIZATION OF ALTERNATE CONTACTS

This authorization form, when completed and signed by you, allows our staff members to speak only with an individual(s) you 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 section as you did the first.

( ) I do not authorize anyone to receive information regarding my medical care.

I authorize the following individual(s):

_____ Name	_____ Name
_____ Phone #	_____ Phone #
____ Appointment ____ Account/Bill ____ Lab results ____ Test results ____ Medical Care	____ Appointment ____ Account/Bill ____ Lab results ____ Test results ____ Medical Care
_____ Name	_____ Name
_____ Phone #	_____ Phone #
____ Appointment ____ Account/Bill ____ Lab results ____ Test results ____ Medical Care	____ Appointment ____ Account/Bill ____ Lab results ____ Test results ____ Medical Care

( ) Home Telephone _____
- ( ) O.K. to leave message with detailed information
- ( ) Leave message with call-back number only

( ) Written Communication
- ( )O.K. to mail to home
- ( )O.K. to mail to work/office
- ( )O.K. to fax to _____

( ) Work Telephone_____
- ( ) O.K. to leave message with detailed information
- ( ) Leave message with call-back number only

( ) Other_____

_____
Patient's name (Please Print)

_____
Date

_____
Patient's Signature