AUTHORIZATION TO LEAVE VOICEMAIL MESSAGE

IMPORTANT: All blanks **MUST** be filled in

Patient Name:	Birthdate:
Address:	Phone:
City/State	Zip code:

I, patient or legal guardian, hereby authorize LITTLE TRAVERSE PRIMARY CARE to verbally leave detailed, personal health information by utilizing the voicemail on the phone numbers listed below:

1. ________________________________
Phone number

2. ________________________________
Phone number

TIME PERIOD: (Circle one) ***INDEFINITE*** ***1 YEAR*** ***SPECIFIC TIME PERIOD***: _________________

Specific Information approved to disclose:

This authorization allows for verbal messages to be left for any and all non-critical health information with the **EXCLUSION** of psychiatric consults and mental illness, developmental disabilities, alcohol and drug treatment, any Communicable disease and infection information as defined by Statue and Michigan Department of Public Health Rules.

I understand, it is my responsibility to notify Little Traverse Primary Care, in writing, should I wish to CHANGE ONE OR MORE, of the telephone numbers listed above.

I understand, as set forth in the practice's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to the Privacy Officer. I understand that a revocation is not effective to the extent the practice has relied on the use or disclosure of the health information.
I understand that I have the right to refuse to sign this authorization or to inspect (or copy) my protected health information to be used or disclosed as permitted under federal and state laws.
I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

- If the patient is 18 years of age or older, the patient must sign and date form
- If the patient is 18 years of age or older and is incapable of signing, a legally authorized may sign and date the form. Please indicate your legal authority and include documentation of your relationship:
  ☐ Legal Guardian/Conservator ☐ Health Care Agent (Health Care Power of Attorney)
- The patient is under 18 and I am the **parent** or **legal guardian** (circle one) signing and dating this form.

____ ______________________
Patient/Guardian/Legal Representative Signature Date

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Printed name of signing patient **IF NOT PATIENT**