Women's Cancer Care Associates, LLC

GYNECOLOGIC ONCOLOGY

AUTHORIZATION TO LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

I hereby authorize Women's Cancer Care Associates, LLC to leave/send detailed personal information by the following means: (please check all that apply)

1) WCCA can leave a voicemail message regarding appointments /medical issues on my:

☐ Home phone ☐ Work phone ☐ Cell phone

2) WCCA can speak/leave message with:

_____ (___)_____ _____ ☐ appointments ☐ med info
name telephone relationship

_____ (___)_____ _____ ☐ appointments ☐ med info
name telephone relationship

_____ (___)_____ _____ ☐ appointments ☐ med info
name telephone relationship

3) WCCA can send mail to my home: ☐ Yes ☐ No

Our practice sends mail to patients for a number of reasons. We may have tried to reach by phone unsuccessfully and we need you to contact our office, it may be time to schedule your next appointment, or we need to notify you of important practice changes.

With my signature below, I acknowledge and understand that this information will be kept in my medical record. It is my responsibility to notify my healthcare provider should I change one or more of the above designations. I also acknowledge that with the authorization of messages on voicemail that other people in my household or workplace may hear the personal health information left on the voicemail message.

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient Signature Date

319 S Manning Blvd Suite 301
Albany NY 12208
(518) 458-1390