Alan J Zend DO PLLC
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Edmonds, WA 98026

Authorization to Leave Personal Health Information by Alternative Means this includes Information Pertaining to Drug and Alcohol Problems and Psychological Conditions

Patient Name:_____ Date of Birth:_____

Patient Mailing Address:_____

_____

(Please check all that apply)

□ May leave/share message on voicemail at home#: (____)_____ _

May leave/share detailed message on voicemail at work# _____

□ May leave/share information with spouse(name):_____

□ May leave/share info with other family named _____

□ May leave/share detailed message on cell phone#:(____)_____

□ May leave/share detailed message at a different number#_____

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters 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 or legally authorized individual signature Date