UT★PHYSICIANS

ORTHOPAEDICS

AUTHORIZATION TO LEAVE RECORDED VOICE MESSAGES

Patient's Name: _____

(*Please Print*)

I hereby give permission for UT Physicians to leave messages regarding office visits, surgery information and appointment confirmations, as well as any other medical information related to my treatment at the following phone number(s) and/or with the following individual(s):

(*Please check all that apply*)

__Home Answering Machine Phone Number: _____

__Family Members (*Please list below*)

Name: _____ Phone Number: _____
Name: _____ Phone Number: _____
Name: _____ Phone Number: _____

__Housekeeper (*Please list below*)

Name: _____ Phone Number: _____

__Work Voicemail Phone Number: _____

__Assistant (*Please list below*)

Name: _____ Phone Number: _____

__ Other (*Please list below*) Phone Number: _____

__ I DO NOT give my permission to UT Physicians to leave any medical information related to my condition to anyone other than myself in a direct manner. Please call me at the following phone number: _____.

_____ _____

Signature **Date**

Relationship: __Self
__Parent or Legal Guardian
__Other:_____