



ADVANCED LAPAROSCOPIC ASSOCIATES, P.C.

CONSENT TO LEAVE MEDICAL INFORMATION WITH SOMEONE OTHER THAN THE PATIENT

I am authorizing the personnel at Advanced Laparoscopic Associates, P.C. to leave information related to my medical care with others if I am not available.

Check all that apply:

_____ I authorize that information can be left with my wife/husband/significant other.
Name of person: _____.

_____ I authorize that information can be left on my voice mail (phone #): _____.

_____ Other:
I authorize that information can be left:
_____.

I understand that this authorization will be valid until I give written notification otherwise.

Signature

Date