



**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