Alternative Contacts Form

(Please Use **BLACK** or **BLUE** Ink Only)

We at River Cities Interventional Pain Specialists take your medical confidentiality very seriously. We will not and cannot release information without your written authorization.

This authorization allows our staff members to speak only with an individual(s) you designate in the event you are not available to receive phone calls or you have an adult member that helps coordinate your medical care. You should not designate your doctor.

As part of our Patient Privacy Policy, we will not leave any health information with any other person unless you specifically authorize below:

_____
Signature

I **do not authorize** anyone to receive information regarding my medical care.

_____
Signature

I **authorize** my physician and the employees of River Cities Interventional Pain Specialists to speak with:

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Name: Relationship:

Phone Number(s):

☐Appointments ☐Account/Bill ☐Lab Results ☐Test Results ☐Medical Care ☐Treatment

Alternate means of contacting me are:

Answering Machine/Voicemail _____

Cell Phone _____

Email _____

Fax Number _____

Other _____

By signing below I understand:

- This authorization will remain in effect unless changed by me while I am a patient at this practice.
- It is my responsibility to notify this office of changes and to complete a new form.
- Any problems and/or questions concerning this form are to be referred to the Privacy Officer.
- That should I desire to revoke this authorization, I will give written notice.

_____

Print Patient Name Date of Birth

_____

Patient/Guardian Signature Date

For Office Use Only		
RCIPS Representative		
Print Name	Signature	Date