Alpine Sports Medicine
2219 North 5th Street
Elko, NV 89801

Notification Authorization

Patient Name: _____

Date of Birth: _____

I give permission for Provider and/or employees of Alpine Sports Medicine to notify me about my healthcare, including, but not limited to, teat results, treatment plans, appointments, prescriptions and account information, with the following people or devices:

Initial each applicable category:

_____ Patient Only

_____ Answering Machine / Voice Mail

_____ Spouse: Name _____

_____ Parent: Name(s) _____

_____ Other: Names(s) _____

Can we call you at work? Yes _____ No _____
Initial Initial

If so, what phone number _____

This authorization will expire on _____ and any changes to this form must be in writing.
Date of Described occurrence

_____ _____
Patient/Guardain Signature Date