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