CANE RIVER SURGERY CENTER

William A. Ball, Jr., M.D., F.A.C.S.
General Surgery
Board Certified by American Board of Surgery

ALTERNATIVE CONTACTS FORM

We at Dr. Ball's office 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:

____ I do not authorize anyone to receive information regarding my medical care.
____ I authorize my physician and the employees of this clinic to speak with:

1. Person: _____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care
2. Person: _____ Relationship:_____
   Phone number(s): _____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care
3. Person:_____ Relationship:_____
   Phone number(s):_____
   ☐ Appointments ☐ Account/Bill ☐ Lab Results ☐ Test Results ☐ Medical Care

Alternate means of contacting me are:_____
My answering machine/voice mail/pager: _____
My Email: _____
My fax number:_____
Other: _____

This authorization will remain in effect unless changed by me while I am a patient at this office. 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 Cane River Surgery Center or Dr. Ball.

I agree that should I desire to revoke this authorization, I will give written notice.

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____

DATE: _____