- ☐ Breast & General Surgical Specialties
- ☐ Bryan Urgent Care
- ☐ Family Medicine of Lincoln
- ☐ Southeast Lincoln Family Medicine & Internal Medicine
- ☐ Bryan Heartland Psychiatry
- ☐ Bryan Women's Care Physicians
- ☐ Holmes Lake Family Medicine & Internal Medicine
- ☐ Bryan Neurology
- ☐ Center for Maternal & Fetal Care
- ☐ Lincoln Aesthetic Surgical Institute

Representatives of Bryan Physician Network are allowed to leave information regarding my status as a patient on my voicemail or answering machine. I realize this information may include pertinent health status and/or financial information.

Patient Name: ______________________________ Date Of Birth: ________________

❑ **I give permission** to leave information on my voice mail or answer machine.

❑ **DO NOT** leave information on my voicemail or answer machine.

❑ **DO NOT** speak to anyone about my health status.

COMMUNICATION AUTHORIZATION

Bryan Physician Network may communicate information to the following people regarding my care as needed:

			Type of information			
			All	Scheduling/ Appointments	Medical	Billing/ Insurance
Name: ____________	Relationship: ______	Phone Number: ______	☐	☐	☐	☐
Name: ____________	Relationship: ______	Phone Number: ______	☐	☐	☐	☐
Name: ____________	Relationship: ______	Phone Number: ______	☐	☐	☐	☐
Emergency Contact Name: ____________	Relationship: ______	Phone Number: ______	☐	☐	☐	☐

Patient or Authorization Signature: ______________________ Relationship: ____________ Date: __________

This authorization expires upon written notice from me. I understand I have a right to revoke this authorization in writing.
The authorization may be revoked in writing delivered to Bryan Physician Network.

The information used or disclosed under this authorization may be subjected to re-disclosure by the recipient and no longer protected by federal privacy laws.

Bryan Physician Network **MESSAGE AUTHORIZATION**

PLACE PATIENT LABEL HERE