Virginia Medical Alliance

# AUTHORIZED REPRESENTATIVE FORM

With my consent, Virginia Medical Alliance may call my home or other designated location and leave a message on voice mail or speak to the authorized representative listed below who can receive information pertaining to my clinical care, including test results, instructions on course of treatment and appointment reminders. With my consent, Virginia Medical Alliance may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, and healthcare operations.

1. Name: ______________________________________________

   Relation to patient: ______________________________________

2. Name: ______________________________________________

   Relation to patient: ______________________________________

Please check the appropriate box if you will allow Virginia Medical Alliance to leave health information on your home phone or other designated voice mail system.

Yes __________ No ________

Please print home, work and cell phone numbers below:

Home #: ______________________________________________

Work #: ______________________________________________

Cell #: ______________________________________________

Patient's Name (Print): ______________________________________

Patient's Signature: ________________________________________

Date: ______________________________________________

5510 Alma Lane, Springfield, VA 22151

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