PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

Patient Legal Name (First, Middle Initial, Last) _____ Date of Birth _____

Phone Number (Home/Cell) _____ Phone Number (Work) _____

1. Alternate Contact Information Authorization

WVCI has my authorization to:

Leave medical information on my home/cell voice mail	☐ Y	☐ N
Contact me at my place of employment	☐ Y	☐ N
Leave medical information on voice mail at my place of employment	☐ Y	☐ N

2. Family / Friends Release of Information Authorization

I authorize WVCI to speak with, and verbally disclose my health information to, the following person(s) regarding my medical care and treatment and payment for those services.

Please note: This form supersedes the information provided on previous forms.

Name	Relationship to Patient	Phone Number	Emergency Contact?
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N
			☐ Y ☐ N

3. Validation and Signature

I understand that I can change this list at any time by notifying WVCI in writing. Written revisions will not affect any action taken in reliance on this consent before the written notice was received.

Signature of Patient _____ *Date* _____

*If this authorization is signed by a patient's personal representative on behalf of the patient, please complete the following:

Name of Personal Representative _____ *Relationship to Patient* _____