Willamette Valley Cancer Institute and Research Center (WVCI)

PATIENT CONSENT FOR PRACTICE TO COMMUNICATE WITH OTHERS

_____ _____

Print Patient's Legal Name – First, Middle Initial, Last **Date of Birth**

_____**(Home/Cell)** _____**(Work)**

Phone Number **Phone Number**

1. Alternate Contact Information Authorization

WVCI has my Authorization to:	Leave medical information on my home/cell voicemail	Y	N
	Contact me at my place of employment	Y	N
	Leave medical information on voicemail at my place of employment	Y	N

2. Family / Friends Release of Information Authorization

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

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

3. Surrogate Decision Maker

If I am unable to make healthcare decisions for myself my surrogate decision maker is named below and WVCI can contact this individual in case of an emergency.

Name of Health Care Surrogate Decision Maker	Relationship to Patient	Phone Number

4. 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