

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

 Phone Number (Primary)

 Phone Number (Work)

1. Alternate Contact Information Authorization

WVCI has my Authorization to:	Leave medical information on my primary phone 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	<u>Y / N</u> Emergency Contact?
Name	Relationship to Patient	Phone Number	<u>Y / N</u> Emergency Contact?
Name	Relationship to Patient	Phone Number	<u>Y / N</u> Emergency Contact?
Name	Relationship to Patient	Phone Number	<u>Y / N</u> Emergency Contact?
Name	Relationship to Patient	Phone Number	<u>Y / N</u> Emergency Contact?

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
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***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
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