family health matters

PRIMARY CARE + WELLNESS

est.2012

Family Health Matters of Salem

PERMISSION TO SPEAK TO

In keeping compliant with HIPAA (privacy) regulation, you have permission to share my medical information to:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Name: Relationship: Phone:

Other providers referred by us, self-referred or Hospitals ☐ **YES** ☐ **NO**

Please check whichever applies:

☐ Yes, you may leave a voicemail message ☐ No, you may not leave a voicemail message

** I understand if I check yes, we will be able to leave normal test results, appointment information that we have scheduled for you, and also confirm your appointments by leaving a message on your machine. I also understand that this is my responsibility to update my demographics of any changes immediately.
** I understand if I check no, I need to indicate below how else we will be able to communicate this information:

Patient Signature ______________________________ Date: ____________________