SELAH MEDICAL CENTER
9. East 1st Ave, Suite 4, Selah, WA 98942
509-697-8008

Name: _____ Date: _____

PATIENT CONTACT PERMISSION

This information will allow us to contact you regarding all medical results, inquiries and other office/medical related issues.

Please list telephone number(s) that we may use to contact:

1. _____ Home Cell Work Best Time to call: _____

2. _____ Home Cell Work Best Time to call: _____

3. _____ Home Cell Work Best Time to call: _____

In the event we are unable to reach you concerning your issues related to this office and/or your treatment may we leave a message:

Home Answering Machine? Yes No

Work Voice Mail? Yes No

Cell Phone Voice Mail? Yes No

If you have provided a work (and/or) home telephone number for us to contact you, and you are unavailable, may we leave a message with the receptionist/operator or family member to have you return the call? Yes No

I have been presented with a copy of the Notice of Privacy practices detailing how my health information may be used and disclosed as permitted under federal and state law and outlining my rights regarding my health information.
_____(initial)

We will never share, sell, or rent individual personal information with anyone.

Please list the names of any person(s) to whom you give us permission to discuss ANYTHING concerning your medical status (i.e., relative, spouse, partner, friend)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Relationship (if not signed by patient): _____