ALTERNATIVE MEDICINE CLINIC

I, _____, ALLOW MY MEDICAL INFORMATION TO BE DISCUSSED WITH:

(PLEASE INCLUDE ANY FAMILY MEMBERS OR OTHER PERSONS, IF ANY, & CONTACT INFO FOR WHOM WE MAY INFORM ABOUT YOUR GENERAL MEDICAL CONDITION AND YOUR DIAGNOSIS (INCLUDING TREATMENT, PAYMENT & HEALTH CARE OPERATION). IF MAY CONTACT ONLY IN CASE OF EMERGENCY PLEASE SPECIFY EMERGENCY ONLY).

A.

B.

C.

D.

I UNDERSTAND THAT MY CONFIDENTIALITY IS IMPORTANT TO ALTERNATIVE MEDICINE CLINIC AND THAT ANYONE WHO IS NOT ON THIS LIST WILL NOT BE GIVEN INFORMATION ABOUT MY VISITS UNLESS THIS DOCUMENT IS AMMENDED BY ME IN WRITING TO ALLOW ALTERNATIVE MEDICINE CLINIC TO DO SO. I ALSO UNDERSTAND THAT PEOPLE ON THIS LIST CAN OBTAIN ANY INFORMATION REGARDING MY VISITS TO ALTERNATIVE MEDICINE CLINIC UNLESS OTHERWISE NOTED IN WRITING.

_____ _____

SIGNATURE **DATE**

PLEASE INDICATE IF YOU WANT ALL CORRESPONDENCE FROM OUR OFFICE SENT IN A SEALED ENVELOPE MARKED "CONFIDENTIAL":

YES _____ **NO** _____

CAN CONFIDENTIAL MESSAGES (IE. APPOINTMENT REMINDERS) BE LEFT ON YOUR TELEPHONE ANSWERING MACHINE OR VOICEMAIL?

YES _____**NO** _____

PATIENT NAME _____ **(GUARDIAN IF UNDER 18)**

_____ _____

PATIENT/GUARDIAN SIGNATURE **DATE**