Medical Clinic
18144 Seco Street |PO Box 535
Jamestown Ca 95327
P. 209-984-4820 | F. 209-984-4825

Wellness Center
18158 Main St
Jamestown Ca 95327
P. 209-782-6446 | F. 209-984-9169

Red Feather Clinic
18232 Smoke St
Jamestown Ca 95327
P. 209-782-8625 | F. 209-984-9240

Patient Authorization To Discuss Protected Health Information

Do you give our office permission to discuss your medical/financial information with a person(s)?

____Yes ____No (if yes, please provide their name and relationship below)

Name:	Relationship:

____

May we leave personal medical information on your answering machine/voicemail: Yes ____ No: ____

Patient Name: ____________________________________

Patient Signature____________________________________ Date: ______________________

Inability to obtain acknowledgement

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgment, and the reason why it was not obtained.

Patient reason for refusing to sign acknowledgement

____

____

Updated 11/18/2020