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

Mathiesen on Main
18268 Main St
Jamestown Ca 95327
P. 209-630-2772 | 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:**	**PHONE NUMBER:**

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 or inability to sign acknowledgement:

_____

_____