Patient Name: _____ DOB:_____

1. Whidbey Island Internal Medicine has my permission to share limited health information with family/friends

I give permission to the person(s) below to receive limited information about my care. I understand my healthcare provider will use professional judgment to ensure that information is shared with my family/friend in order to assist with my continuing care. Any information requested that does not pertain to assisting with my health care and any requests for copies of medical records will require a signed authorization. This permission will be considered ongoing until I state otherwise.

Name of Individual	Relationship to Patient		Patient Initials

****
****

2. Whidbey Island Internal Medicine, has my permission to: (Please check all boxes that apply)

Patient Initials

☐ Leave message at home with: ⇨ NAME: _____ ☐

☐ Leave detailed message on answering machine: ⇨ Phone Number: _____ ☐

☐ Leave message on cell phone. ⇨ Cell phone number: _____ ☐

☐ Leave message at work ⇨ Work Number: _____ ☐

These agreements are for Whidbey Island Internal Medicine and its associates, not to be shared with other facilities.

_____ _____

Signature of Patient or Legal Guardian Date

_____ _____

Printed Name of Patient or Legal Guardian Relationship (if not self)