EMERGENCY CONTACT INFORMATION

In case of an emergency, I, ___________________________ give permission to contact the person(s) listed below:

1. Name: _______________________________Relationship:__________________________

   Phone - Cell: __________________________Work:________________________________

2. Name: _______________________________Relationship:__________________________

   Phone – Cell:___________________________Work:________________________________

3. Name: _______________________________Relationship:__________________________

   Phone – Cell:___________________________Work:________________________________

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Patient or Guarantor's Signature   Date

PERMISSION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby acknowledge that I received a copy of this clinic's Notice of Privacy Practices. I further acknowledge that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

I, ________________________________, give my permission for McCammond Family Medicine to give information to the people listed below about my medical care. This information may include, but is not limited to, lab information, medications being taken, appointment times, changes in appointments, X-ray results, progress reports about me, needed or completed treatment, and any other information that this office has about me. (Please do not include other provider, insurance companies, or employers in this list.)

________________________________ Relationship ________________________________

________________________________ Relationship ________________________________

________________________________ Relationship ________________________________

________________________________ Relationship ________________________________

________________________________ Relationship ________________________________

________________________________ Relationship ________________________________

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Patient or Guarantor's Signature Date