West Texas Family Medicine

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To patient:

Your health information is protected and confidential. In order for the staff of West Texas Family Medicine to discuss your health related matters with family, friends, caregivers or other designated persons, please complete the following information.

Patient Name:____ **DOB**:__________________________

Relevant health information may be shared with the following family members, other relatives, close personal friends, or other person identified:

____ __________________________________
(Name) (Relationship)

____ __________________________________
(Name) (Relationship)

____ __________________________________
(Name) (Relationship)

____ __________________________________
(Name) (Relationship)

____ __________________________________
(Patient Signature) (Date)

____ __________________________________
(Witness Signature) (Date)

West Texas Family Medicine

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Date:_______________________________________

Patient Name:____

Date of Birth:________________________________

"Notice of Privacy Practices"

By signing this form, I am acknowledging that I have been offered and have received a revised copy of the "Notice of Privacy Practices" from
West Texas Family Medicine

Signature:____
(Guarantor signature if patient is a minor)

Witness:____