Water's Edge
NATURAL MEDICINE

## Consent for Leaving Messages/Share Information with Family/Friends

I understand that my healthcare information at Water's Edge Natural Medicine is protected and I have received a copy of the Notice of Privacy Practices.

In order for the clinic to leave detailed messages on my voice mail or answering machine, I need to give permission to Water's Edge Natural Health Services.

**Consent for Leaving Messages** (please check box)

□ Yes □ No best number to leave messages_____

I consent to information regarding myself (or my child's) appointment reminders/instructions be left on my voicemail or answering machine.

**Consent for Shared Information with Family and Friends** (please check box)

□ Yes □ No

I wish family members or friends to have access to my healthcare information. The name(s) listed below are family members or friends to whom I grant access to my healthcare information. I will rely on the professional judgment of my provider and her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information form.

| NAME | RELATIONSHIP |
|---|---|
| 1._____ | _____ |
| 2._____ | _____ |
| 3._____ | _____ |

**(print)**_____ _____

**patient name** **patient/parent signature**

**date of birth**_____ **date**_____

This consent will be considered valid until such time that I cancel it. I reserve the right to cancel it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships change may change over time. I understand that any cancellation can only apply to future disclosures or actions regarding my protected health information and cannot cancel actions taken or disclosures made while the designation was in effect.