FAMILY CARE CENTERS
MEDICAL GROUP INC

Woodbridge Walk-In
4950 Barranca Parkway Ste. 104
Irvine, CA 92604

Communicating with You

To effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left for your physician's office. **We may communicate with you through mail, secure email (NextMD Patient Portal), and telephone, including leaving messages on your answering machine's/voice mail.**

Please check all boxes that give Family Care Centers permission to use for your communications:

❑ You may contact me by telephone *Phone Number: _____ ❑ Message OK ❑ Cell ❑ Home ❑ Work

*Phone Number: _____ ❑ Message OK ❑ Cell ❑ Home ❑ Work

*Phone Number: _____ ❑ Message OK ❑ Cell ❑ Home ❑ Work

Please list any persons you would like to have access to your billing, office visit or health information, such as your spouse, caretaker or other family member. We will ask for additional consent prior to releasing information related to Behavior Health and/or HIV test results.

Name/Phone Number	Relationship	Options
1.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information
2.		❑ Billing Information ❑ Appointment Information ❑ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I received a copy of the notice of Privacy Practices for the above medical practice. I further acknowledge that a copy of the current notice is posted in the reception area and that any amended notice of Privacy Practices will be made available at my next appointment.

If **not** signed by the patient, please indicate:

Relationship:

- ◉ Parent or guardian of minor patient
- ◎ Legal Guardian or conservator of an incapacitated patient
- ◎ Beneficiary or personal representative of deceased patient

Name of Patient, if patient **NOT** signing: _____

_____ _____ _____

Print Name of Patient/Responsible Party | Patient Date of Birth | Todays Date

_____ _____

Signature of Patient/Responsible Party (Print) | Relationship to Patient