Valley View Family Practice Associates

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Patient Name:	DOB:		
In accordance with our Electronic Medical Record from you on how you prefer to be contacted by Va Practice uses an automated system to confirm app automated calls or have any other concerns regar written explanation on a separate piece of paper	alley View Family Practice pointments. If you do not rding how we get in touch	e. Valley View wish to partic	Family cipate in the
By marking yes, you are agreeing to regarding appointment information, minformation, etc.	-	_	
May we call your home phone?		Y	N
May we call your mobile phone?		Y	N
May we text your mobile phone?		Y	N
May we call you at your place of wor	ck?	Y	N
May we send mail to your home addres	3 s ?	Y	N
May we email/patient portal you?		Y	N
As stated in our Notice of Privacy Practices, we friend, etc.) protected health information (PHI your healthcare. We request that you designate health and other information about your care heremergency we will contact them in order.) that directly relates th here, individuals with who	nat person's in	nvolvement in uss your
Contact 1.) Name:	Relationship:		Phone #:
Contact 2.) Name:	Relationship:		Phone #:
Signature:	Date:		