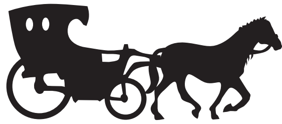

**FAMILY MEDICAL CENTER**

*Joel G. Wright M.D. • Clinton D. Damron D.O. • Matthew R. Sampson M.D. • Trina S. Gomm FNP-BC*

**1492 S. 20th Avenue, Safford, AZ 85546 • Phone: (928) 348-2151 • Fax: (928) 428-3617**

# Authorization to Schedule Testing/Office Visits/Medical Information and Results of Progress or Prognosis

Patient Name: ____________________________________ Date of Birth _____/_____/_____

I authorize Family Medical Center to talk to the following people regarding my scheduling, office visits, medical information and results if I am unavailable:

☐ No one other than myself

☐ My Spouse (name of spouse) ________________________________________________

☐ My Children (name of children) ______________________________________________

☐ Message on my answering machine/voicemail at the following number(s)/ or any other phone number

________________________________________________________________________

________________________________________________________________________

I understand that this statement will remain in effect until I notify Family Medical Center in writing of any changes.

Patient Signature _______________________________________ Date ___________________