Lopez Island Pharmacy Patient Notification Form

Use this form to tell us who is involved in your care, so that we may provide them with the information they need to assist you. We will act upon the information you provide on this form unless you inform us that it has changed. This form does not apply in the hospital setting.

Circle Choice

Yes **No** You may leave messages at my home, or on my telephone, or cell phone regarding my health care and any appointment information.

Yes **No** You may leave automated telephone appointment notifications.

Yes **No** You may speak to family members or friends regarding my health care.

The individuals listed below are involved in my ongoing care. Lopez Island Pharmacists and staff may provide them with limited information about my condition and care as needed to assist me. I understand that information specific to drug and alcohol treatment, psychiatric conditions, and HIV/AIDS may be included.

Family Member/Friend	Relationship	Contact Number

Other Information

Do you have a Living Will? □ Yes □ No Do you have Power of Attorney? □ Yes □ No

Power of Attorney name? _____

I am satisfied with the explanation regarding this form that I request and received.

_____

Signature of patient or person authorized to sign for patient Relationship Date Time