## Release of Information

I, _____ DOB:____/_____/____ , hereby give consent to Grand Medical Clinic and its staff to access any and all medical records necessary for continuum of care. I understand that I may refuse, in writing, the release of any and all records per right under HIPAA. I have been given a HIPAA information sheet and understand when, where and how the clinic may, in turn, release my information, unless I specify otherwise.

_____ _____

Patient's signature Date

I, _____ hereby give consent to the following people to discuss my records, and/or results, with the doctor and his staff if needed.

1._____ Relationship:_____Phone:_____

2._____ Relationship:_____Phone:_____

3._____ Relationship:_____Phone:_____

4._____ Relationship:_____Phone:_____

I understand that this authorization can be revoked, in writing, at any time and may apply to one or more of the above people.

_____ _____

Patient signature Date

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## Appointment Policy

Our goal is to provide quality individualized medical care in a timely manner. Late arrivals, cancellations, and "no shows" inconvenience those individuals who need access to medical care in a timely manner. We would like to remind you of our office policy regarding missed appointments.

**Late arrivals**

Failure to arrive within 15 minutes of your scheduled appointment time may result in a delay of services. While we will do our best to accomodate you, we may find it necessary to reschedule your appointment. These policies enable us to better utilize available appointments for our patients in need of medical care.

**Cancellation of an Appointment**

In order to be respectful of the medical needs of other patients, please be courteous and call Grand Medical Clinic promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in the need for treatment. If it is necessary to cancel your scheduled appointment, we acquire that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. To cancel appointments, please call 832-437-5218

_____ _____ _____

Signature of patient or personal representative Printed name of patient or personal representative Date