

Contact Preferences

This form is used to release your protected health information as required by federal and state privacy laws. Your authorization allows Wellness Concepts, LLC to release your protected information to a person or organization that you choose. Any information obtained will be only that which is relative to your care inside our office. You can revoke this authorization at any time by submitting a request in writing to Wellness Concepts, LLC. Revoking this authorization will not affect any action taken prior to receipt of your written request.

1. Patient Information: (individual whose information will be released)

Name: (First, Middle, Last, Title)

Birthdate (MM/DD/YYYY)

Home Telephone _____

May we contact you here? (Y__N__) May we leave a message at this number? (Y__N__)

Work Telephone _____

May we contact you here? (Y__N__) May we leave a message at this number? (Y__N__)

Mobile Phone _____

May we contact you here? (Y__N__) May we leave a message at this number? (Y__N__)

Email _____

May we contact you at this address? *We use email addresses for internal purposes only. No information will be given to anyone outside of this office.* (Y__N__)

2. Emergency Contact Information: In the event of an emergency, who would you like us to contact?

Patient Signature _____

Date _____