WRH PHYSICIANS, INC.

Disclosure of Personal Health Information

Personal Health Information Release/Emergency Contacts:

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Home Phone #:_____ Home Phone #:_____

Cell Phone #: _____ Cell Phone #:_____

Is this persona able to receive your personal health information? Yes No

Is this persona able to receive your personal health information? Yes No

Name:_____ Name:_____

Relationship:_____ Relationship:_____

Home Phone #:_____ Home Phone #:_____

Cell Phone #: _____ Cell Phone #:_____

Is this person able to receive your personal health information? Yes No

Is this person able to receive your personal health information? Yes No

On occasion, we may need to call and leave information regarding results of any treatments or tests that you have had.

May we leave this information on your voicemail? Yes No

If yes, please list your preferred contact number: _____ circle one: Brief / Extended

May we leave appointment reminders on your voicemail? Yes No

If yes, please list your preferred contact number: _____

I, _____, do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies and Procedures.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____