

I hereby authorize the Wright Health & Wellness Center to release my private health information to the following individuals/organizations for the indicated purpose:

Name

I request the following restrictions to the use and/or disclosure of my private health information:

Yes No I authorize the Wright Health & Wellness Center to leave appointment reminders and/or medical information on my **home** voicemail, message service, or answering machine.

Yes No I authorize the Wright Health & Wellness Center to leave appointment reminders and/or medical information on my **office** voicemail, message service, or answering machine my office.

Yes No I authorize the Wright Health & Wellness Center to leave appointment reminders and/or medical information on my **cell phone** voicemail, message service, or answering machine.

Please Print Your Name

Signature of Patient or Legal Representative

Date Notice Effective

Do Not Write Below – Office Use Only

The Wright Health & Wellness Center <input type="checkbox"/> accepts <input type="checkbox"/> denies or <input type="checkbox"/> accepts conditionally the restrictions imposed on release of information as stated above.		
_____ Signature	_____ Title	_____ Date