



WRH PHYSICIANS, INC.

DISCLOSURE OF PERSONAL HEALTH INFORMATION

Please list below the names and contact information of individuals you authorize to receive your Personal Health Information (PHI)

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____

<p>For security purposes, please fill in one of the personal identifiers on the right so that we may verify whom we are speaking with before sharing your <u>Personal Health Information (PHI)</u></p>	Mother's Maiden Name: _____
	Your city of birth: _____
	Your favorite color: _____
	Create your own identifier: _____

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

May we leave this information on your voicemail?	Yes	No
May we leave appointment reminders on your voicemail?	Yes	No
If yes, please list your preferred contact number.	Preferred phone #: _____	

Please list the name(s) below of the individual(s) that you would like us to contact in case of emergency:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Home Phone: _____	Home Phone: _____
Cell Phone: _____	Cell Phone: _____

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

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____