Wisdom Health

Permission To Share Information

Name ____ Birthdate__________________

_____ Yes, I give permission to Wisdom Health to share information or records about myself to the person(s) listed. The information must be relative to my ongoing medical care and treatment. (Details about what information may be disclosed can be found in our Notice of Privacy Practices)

[If you are a resident of Frasier Meadows and want Wisdom Health to be able to share your information with Frasier Meadows staff (only as needed to coordinate your care), list "Frasier Meadows Staff" on one of the lines below.]

1. ____

2. ____

3. ____

4. ____

_____ No, do not share information or records about myself with other individuals unless allowed or required by law.

Answering Machine Messages

_____ I give my permission for Wisdom Health to leave information on my answering machine and the answering machine of anyone listed above, and am aware that the information may include details about my health and medical care.

_____ Do not leave information on my answering machine, other than a message that Wisdom Health called. I understand I will have to return the call in order to obtain the information intended for me.

____
Signature

____
Date

This authorization remains in effect until changes are made in writing and delivered to the Wisdom Health office.