Comprehensive Psychological & Wellness Center, LLC

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RELEASE OF MEDICAL INFORMATION REQUEST

Patient Name:_____ Date of Birth:_____ SS#:_____

Emergency Contact:_____Telephone Number_____

We are required by federal and state law to maintain the confidentiality of our patients' medical records and therefore, we may not discuss or release information to anyone unless authorized by the patient or his or her legal guardian (if applicable) to do so. We want to make sure that you receive information that is necessary to assist us in providing quality care and service. **Please indicate the numbers that you would like to be called at. In order to be called at any of these numbers you must check off "Leave Voicemail and/or Leave message with person answering." In addition, as a courtesy we make confirmation calls or texts regarding your appointment. Please advise how you would like to receive these reminder calls**.

Telephone Home Phone Number (Indicate Number) _____

☐ It is ok to send text message, leave a message on voicemail, and/or leave a message with the person answering.

Telephone my work (Indicate Number) _____

☐ It is ok to send text message, leave a message on voicemail, and/or leave a message with the person answering.

Telephone my cell (Indicate Number) _____

☐ It is ok to send text message, leave a message on voicemail, and/or leave a message with the person answering.

Email (Indicate E-mail address) _____

☐ It is ok to send e-mails to this address.

Please only select one option for confirmation calls.

☐ Home Phone Number ☐ Work Phone Number ☐ Cell Phone Number

☐ Text ☐ Voice Call

Patient Name (Printed):_____Patient Signature:_____

Date:_____

Parent/Guardian Name (Print)_____Parent/Guardian Signature:_____

Date:_____

Submit Form Reset Form