BodyWise Therapy

Contact Information/ Permission to Release Information

Please identify how you would like us to reach you by phone:

May we call you at home?	_____Yes	_____No
May we leave a message at home?	_____Yes	_____No
May we call you on your cell phone?	_____Yes	_____No
May we leave a message on your cell phone?	_____Yes	_____No
May we call you at work?	_____Yes	_____No
May we leave a message at work?	_____Yes	_____No
Do you wish to receive information by email:	_____Yes	_____No

Email Address:_____

In compliance with our strict confidentiality guidelines we are asking you to list anyone that we may release medical or billing information to, including spouse or other family members. If this information changes at anytime, you must request a new form from our staff. **The last 4 digits of the patient's social security number will be required upon request of information**.

Permission to release treatment or billing information to:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Name Relationship

_____**Please release treatment and billing information to patient only.**

_____ _____
Signature Date

_____
Print Name

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