Wise Health System

Affiliated with, but not controlled by, Baylor Scott & White Health or its subsidiaries or community medical centers

PERMISSION TO GIVE MEDICAL INFORMATION

Patient Name: ______________________________ DOB: ____________

Please contact me as follows (please check all that apply)

Home Telephone: ______________________
______ Leave a message with appointment time and date.
______ Leave a message with call back number only.
______ Leave a message with a family member.
______ Do not leave a message.

Cell Telephone: _______________________
______ Leave a message with appointment time and date.
______ Leave a message with call back number only.
______ Leave a message with a family member.
______ Do not leave a message.

Work Telephone: ______________________
______ Leave a message with appointment time and date.
______ Leave a message with call back number only.
______ Leave a message with a family member.
______ Do not leave a message.

In addition to any of my treating physicians and other medical professionals, I authorize the release of medical information to:

Name: ______________________________ Date of Birth: _____________

I authorize the release of financial information to:

Name: ______________________________ Date of Birth: _____________

I understand that I have the right to change this authorization at any time.

________________________________ ________________
Patient or Guardian Signature Date