PERLIS WELLNESS CENTER

Cheryl Perlis, MD
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www.perliswellnesscenter.com

PATIENT PRIVACY ACT / INFORMATION AUTHORIZATION

Patient Name: _____ DOB: _____

I give permission to Perlis Wellness Center and any of its employees, contractors and affiliates, to disclose my health information to the following person(s). This may include, but is not limited to, picking up my medical records, prescriptions, any communications, etc. regarding my health information. (Please include any physicians, relatives and friends you are allowing to take part in caring for your health).

Print clearly.

1. _____ Relationship: _____ Phone Number: _____
2. _____ Relationship: _____ Phone Number: _____
3. _____ Relationship: _____ Phone Number: _____
4. _____ Relationship: _____ Phone Number: _____
5. _____ Relationship: _____ Phone Number: _____

If you are not available at the time of our call, may we:

Disclose medical information on an answering machine or voice mail? □ Yes □ No

Leave appointment information on an answering machine or voice mail? □ Yes □ No

It is the responsibility of you, the patient, to contact us with any changes to the above information in writing.

Patient or Guardian Signature Date