WAKE
PSYCHIATRY

DISCLOSURE AND CONSENT FORM

Patient Name _____

_____ I authorize the specified information below to be disclosed to the specified individuals below.

Name: _____ Relationship: _____ ◯ Financial/Billing ◯ Medical Information

Name: _____ Relationship: _____ ◯ Financial/Billing ◯ Medical Information

Name: _____ Relationship: _____ ◯ Financial/Billing ◯ Medical Information

This authorization will expire two years from today. I have the right to revoke this authorization at any time by stating this in writing and sending my written revocation to Wake Psychiatry PLLC.

Expiration Date: _____

_____ I DO NOT authorize my health information to be shared with anyone other than my insurance company. My refusal will not affect my ability to obtain healthcare treatment, payment or eligibility for benefits.

Regarding Messages

(Please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments

____ I authorize you to leave a detailed message on my home or cell number regarding medical treatment, care, test results or financial information

____ I authorize you to leave a message with anyone who answers the phone

____ Messages may only be left with _____

_____ _____

Patient/Representative Name (PLEASE PRINT) Date

_____

Patient/Representative Name Signature