Reproductive Health & Wellness Center

PATIENT AUTHORIZATION TO ALLOW REPRODUCTIVE HEALTH AND WELLNESS CENTER TO LEAVE PERSONAL HEALTH INFORMATION

In order to comply with HIPPA Privacy Regulation, an authorization is required from the patient in order to leave detailed messages. This is to protect the privacy of the patient.

By signing this form, I authorize the doctor/and or staff of Reproductive Health and Wellness Center to leave voice messages regarding my personal health information, such as appointments, test results, patient instructions, follow up care, and other information as necessary.

Please check appropriate choices and add phone numbers where we are able to leave a message.

☐ Cell (_____)_____
☐ Home (_____)_____
☐ Work (_____)_____
☐ I do not consent to messages being left at home, work, cell or with any other person. I wish to be contacted directly.

I also authorize my permission to leave detailed messages with:

Name _____

☐ Cell (_____)_____
☐ Home (_____)_____
☐ Work (_____)_____

I have the right to revoke authorization and understand that I must submit a written request once this form is signed.

Patient's Name	**Patient's Signature**	**Date**
Partner's Name	**Partner's Signature**	**Date**
RHWC staff	**RHWC Signature**	**Date**