



INTERNAL MEDICINE & PEDIATRICS WELLNESS CENTER  
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## DISCLOSURE OF PROTECTED HEALTH INFORMATION

By law, medical information is confidential unless written authorization is given. Therefore, upon signing this form, I \_\_\_\_\_ am authorizing Internal Medicine & Pediatrics Wellness Center to give medical information to:

\_\_\_\_\_  
*(Name of authorized person/persons)*

Do  Do not give bill and account information to above named person/persons  
DO NOT DISCLOSE MEDICAL INFORMATION TO ANYONE OTHER THAN MYSELF \_\_\_\_\_

*Initial*

Please indicate how you would like us to communicate appointments and test results : Email like regular mail can be intercepted, therefore only normal results and messages will be sent this way.

Do  Do not: Email me : If yes: address \_\_\_\_\_

Do  Do not Leave messages on answering machine or voicemail

Do  Do not Call me at home if not, please provide alternate telephone contact information:  
\_\_\_\_\_

Do  Do not mail appointment reminders or other correspondence to my home. If not, please provide alternate mailing address:  
\_\_\_\_\_  
\_\_\_\_\_

This remains in effect until I give written notification to discontinue.

\_\_\_\_\_  
*Signature of Patient or Legal Guardian*

\_\_\_\_\_  
*Date*

*Parent/Guardian of minors under age 18 has access to medical records, with the exception of any State Law protecting the privacy of information or minors*