



BodyWise Therapy

Contact Information/ Permission to Release Information

Please identify how you would like us to reach you by phone:

May we call you at home? _____ Yes _____ No

May we leave a message at home? _____ Yes _____ No

May we call you on your cell phone? _____ Yes _____ No

May we leave a message on your cell phone? _____ Yes _____ No

May we call you at work? _____ Yes _____ No

May we leave a message at work? _____ Yes _____ No

Do you wish to receive information by email: _____ Yes _____ No

Email Address: _____

In compliance with our strict confidentiality guidelines we are asking you to list anyone that we may release medical or billing information to, including spouse or other family members. If this information changes at anytime, you must request a new form from our staff. **The last 4 digits of the patient's social security number will be required upon request of information.**

Permission to release treatment or billing information to:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

_____ Please release treatment and billing information to patient only.

_____	_____
Signature	Date

Print Name