

Natural Health & Wellness Center
70 West Railroad Avenue Jamesburg, NJ 08831
(732) 641-2217 www.docwendel.com

Patient's Authorizations for Release of Information

As part of your care in this office a considerable amount of information is recorded about you. We take it very seriously that this information **MUST** be kept strictly confidential. For this reason, only you can authorize the release of this information. Without your authorization, absolutely **NO** information will be released to anyone under any circumstances, unless there is a court order forcing the release of that information. **Please fill in you name and identification information, read each item, check the appropriate box, date and sign this form at the bottom.**

Name: _____ Date of Birth: _____

Current Address: _____

Contact #s: _____

HOME

WORK

CELL

Each of the following authorizations pertains to the Natural Health & Wellness Center of Dr. David Wendel, D.C. and the members of this office staff.

1. I authorize do NOT authorize the release of information to my insurance company.
2. I authorize do NOT authorize the writing of my name on the office message/birthday board.
3. I authorize do NOT authorize the release of my information to any other health care provider that is involved in my care, treatment, and/or therapy.
4. I authorize do NOT authorize the discussion of my case/care with anyone except for those authorizations given in items 1, 3, 9 and 10. If this is checked DO NOT fill in any information in items 5 and 8!
5. I authorize do NOT authorize the discussion of my case/care with **ONLY** the following persons:
My spouse whose name is: _____
My parents whose names & phone numbers are: _____

My adult children whose name(s) & phone number(s) is/are: _____

My sibling(s) whose name(s) & phone number(s) is/are: _____

My friend(s) whose name(s) & phone number(s) is/are: _____

6. I authorize do NOT authorize the leaving of messages about my appointments and treatment on my voice mail/answering machine.
7. I authorize do NOT authorize Dr. Wendel and his staff to contact me by telephone at the numbers listed above and by email at: _____@_____ to discuss my appointments, treatment information, and/or other details related to my therapy, treatment, and/or care in his office. This includes but is not limited to financial issues (insurance, balance due, etc) related to my care as well as anything related to the treatment that has or will be provided to me.
8. If I am not available, Dr. Wendel and his staff u are u are NOT authorized to speak with the relative(s) and/or friend(s) noted in item 5 above about all the items listed in item 7 above.
9. I authorize do NOT authorize the discussion of my case/treatment with an attorney and/or health care provider that represents me or my insurance company.
10. I authorize do NOT authorize the submission of my diagnostic studies (including but not limited to x-ray, CT scan, MRI, sonogram, blood tests, Doppler, etc.) to an independent health care provider and/or diagnostic evaluation service for the purpose of obtaining a second opinion and/or more in depth evaluation of my condition.

The above authorizations are valid until I rescind them with written notice and a photocopy of these authorizations if to be considered as valid as the original.

Date

Signature of Patient

Signature of Parent/Guardian