BW PRIMARY CARE
Bridge to Wellness

Name: _____ DOB: _____ Date:_____

PATIENT COMMUNICATION AUTHORIZATION
Release of Information

BW Primary Care is dedicated to preserving your right to privacy, and personal health information.
We are requesting you complete this Patient Communication Authorization in order to continue to provide the finest medical care possible. This authorization allows us to contact you with things such as reminder calls for appointments, and updating your personal information.
Please take a moment to review this sheet, and sign and date below.

I authorize BW Primary Care, LLC. to

Call my home and/or work to remind me of upcoming appointments. In the event I am not available, leave a message on an answering machine.

Send reminder notices for upcoming appointments or when it's time to schedule an appointment.

Call my home or work and leave a message to contact the office. Make and/or receive calls from pharmacies on my behalf, including prescriptions by fax.

Update my personal demographic information either on the phone or in the office at the time of my appointment.

At my request, I give permission to discuss my personal health with the designated person(s) below.

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

Name:_____ Relationship:_____ Phone#:_____

Signature:_____ Date:_____