Wilson Medical Group, PLLC

Privacy Practice Acknowledgement of Receipt

Our notice of Privacy Practices provides information about how we may use and disclose protected health information. It also provides information about your rights as a patient of our practice and who you may contact at our office to ask questions about our privacy practices. This policy is on our web page at www.wilmedgroup.com, or you may also request a copy from our office.

By signing this form below, you agree you have had the opportunity to read our Notice of Privacy Practices.

Authorization to Release Patient Information to Others

We make appointment reminders calls to your primary phone number, and email reminders through our Patient Portal to web enabled patients.

Other persons to which Wilson Medical Group may release ALL information concerning my medical care: (Please list)

_____ _____

Name/Relationship Contact Number

_____ _____

Name/Relationship Contact Number

_____ _____

Name/Relationship Contact Number

Please list any results/information that you do not wish to disclose to the names listed above.

_____

_____

Patient Rights:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed or described in this document by sending a written notification to Wilson Medical Group, PLLC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information to be disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state laws.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This Authorization shall be in effect until revoked by patient.

_____ _____ _____

Patient Name (Print) **Patient Signature** **Today's date**