ClearPoint WELLNESS

AUTHORIZED CONTACT INFORMATION AND RIGHT TO SHARE

Doctors & Practitioners Managing Your Care

By checking yes & initialing, I authorize Clear Point Wellness to share and exchange information including protected, detailed health information and treatments with the following healthcare providers or entities (additional entries may be made on the reverse):

Healthcare Provider's Name	Discipline	Contact Number	Permission to Exchange PHI (Initial)	Satisfaction with Practitioner
______________	________	________	☐Yes ☐No ____	☐OK ☐Good ☐Great
______________	________	________	☐Yes ☐No ____	☐OK ☐Good ☐Great
______________	________	________	☐Yes ☐No ____	☐OK ☐Good ☐Great

Other Right to Share

I authorize Clear Point Wellness to share and exchange information including detailed, protected health information (PHI) and treatments with the following individuals or entities (additional entries may be made on reverse):

Printed Name	Contact Number	Emergency Contact?
______________	______________	☐Yes ☐No
______________	______________	☐Yes ☐No

Emergency Contact

I authorize Clear Point Wellness to *contact* the following individual(s) should an emergency arise. I also authorize Clear Point Wellness to *share and exchange information* including detailed, protected health information (PHI) and treatments.

Printed Name	Contact Number
______________	______________
______________	______________

I authorize Clear Point Wellness to use or disclose my health information in the manner described above.

______________________ Printed Name

______________________ Authorized Provider Representative

______________________ Signature

______________________ Date