Whole Life Health Care
NEW DIRECTIONS IN FAMILY MEDICINE
100 Shattuck Way, Suite 100 · Newington, NH 03801 · Phone 603-431-6677 · Fax 603-610-2232
www.mywholelifehealthcare.com

Authorization for Disclosure of Medical Information
No show / Missed appointment policy

PATIENT NAME: _____ DATE OF BIRTH: _____

Due to the Privacy Act please list names of anyone you would like to have access to your medical information. Please understand that without your consent, we will deny any request for information to family members etc. Only the names listed below will be given any information regarding your medical condition.

I hereby authorize Whole Life Health Care, its staff and Providers to disclose my protected health information to the following representative:

NAME: _____ PHONE: _____
RELATION TO PATIENT: _____

NAME: _____ PHONE: _____
RELATION TO PATIENT: _____

This authorization is valid for one year unless specified: _____

You have a right to revoke this authorization at anytime by notifying Whole Life Health Care in writing. Whole Life Health Care, its staff and providers may deny access to protected health information to the above representative in certain situations and conditions.

A parent/ guardian must accompany a minor patient on all of the office visits, unless written consent of the parent or legal guardian is received. We may see patients aged 14 and older for family planning related visits without the consent of a parent/ guardian.

In compliance with the Federal Law regarding patient's privacy, we ask you to read the "Notice of Privacy Practices", that is available to view at the office. I understand that I have been provided the opportunity to review this document prior to signing this consent, and that a written copy will be provided to me upon request.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to arrive for their visit on time. If it's necessary to reschedule the appointment, please call us immediately.

A minimum of **24 hours cancellation** notice is required for appointments. If less than a 24 hours cancellation is given, the appointment becomes a "Missed" appointment. If you do not cancel in advance and do not present to the office for your appointment, this will be considered a "No show" appointment. If you incur 3 "No show/ missed" appointments within a one year period you may face discharge from the practice.
If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule.

_____ _____
PATIENT SIGNATURE (Parent/Guardian) DATE

Reviewed July 2012