HENRY WOODWORTH, M.D., P.C.

reconstructive psychiatry

for a sustainable consciousness

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CONTACT CONSENT FORM

We want to make sure that your medical information remains secure and that we are in compliance with HIPPA privacy requirements. Please let us know below with whom we may discuss your treatment, if any. This may be a parent, a significant other to whom you are not legally married, or anyone else who you feel should be party to your information.

You are welcome to update this form at any time. Simply print a blank copy from our website, complete it, and bring it with you to your next appointment. Alternatively, you may request a blank copy when you come into the office and complete it while you are waiting.

Client Name_____

I authorize Henry Woodworth, MD, PC, to share my medical information with the following:

_____

Name Telephone number Relationship

_____

Name Telephone number Relationship

_____

Name Telephone number Relationship

Signature of client_____ Date_____
(or parent or legal guardian if client is a minor)

Updated 4/15/16