ARKANSAS PAIN CARE CLINICS
+
PHYSICAL THERAPY AND REHAB

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE FORM)

Name: _____ Date of Birth: ____/____/_____

RELEASE OF INFORMATION

[ ] I authorize the release of information including diagnosis, records, examination(s) rendered to me, and claims information. This information may be released to:

[ ] Spouse _____

[ ] Child(ren) _____

[ ] Other _____

[ ] Information is NOT to be released to anyone.

This release of information will remain in effect until terminated by me in writing.

MESSAGES

Please call [ ] my home [ ] my work [ ] my cell Phone #:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____