ARKANSAS PAIN CARE CLINICS
+
PHYSICAL THERAPY AND REHAB

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____

DOB: _____ SSN: _____

1. I authorize the use and/or disclosure of my health information to Arkansas Pain Care Clinics as described below:

- All imaging reports
- All EMG/NCS reports
- All EKG reports
- Last 3 office notes
- Last 3 procedure notes

2. The following organization and/or medical provider is authorized to make disclosure:

Name of Facility: _____

Please fax requested records to:
Arkansas Pain Care Clinics
Physical Therapy and Rehab
7481 Warden Road
Sherwood, AR 72120

- 501-918-9192
- 501-295-7679

Patient Signature: _____ Date: _____