MEDICAL INFORMATION/HIPAA RELEASE FORM

Rehabilitation Physicians Inc.
1999 Sproul Rd. #10
Broomall, PA 19008

NAME OF PATIENT: _____ DATE OF BIRTH: _____

RELEASE INFORMATION

I authorize the release of information including the diagnosis, treatment records or other records, examinations rendered to me and claims information. This information may be released to:

SPOUSE (name): _____

CHILD OR CHILDREN (name or names): _____

OTHER (name): _____

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

PLEASE CALL: ☐ my home ☐ my work ☐ my cell ☐ OTHER: _____

If unable to reach me:
☐ You may leave a detailed message.
☐ Leave a message asking me to return you call.
☐ OTHER _____

The best time to reach me is: (DAY) _____ BETWEEN (TIMES) _____

SIGNED: _____ DATE: _____

WITNESSED: _____ DATE: _____