PMRC

The Pain Medicine and Rehabilitation Center

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357 Tanger Blvd., Suite 201
Seymour, IN 47274

1730 Williamsburg Dr., Suite 4
Jeffersonville, IN 47130

Authorization Release of Health Information

_____ authorize THE PAIN MEDICINE AND REHABILITATION CENTER (PMRC) to release my health information, by phone, fax, mail or in person to the following individuals who take part in my health care. List name of person(s) you authorize PMRC to speak with, or leave messages with, including those allowed to pick up prescriptions on your behalf. IF A PERSON'S name is not on this list WE CANNOT give any information including authorizing prescription pick up. Do not use this form to list employers, attorneys, case workers or other physicians.

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

This authorization will be in force and effective from_____
Today's date

And will be effective as long as I am receiving treatment at the PMRC unless otherwise documented by an updated document such as this.

This authorization is ONLY given to the family member or friends that I have listed above who take part in my healthcare. This does not include employers, attorneys, case workers or other physicians.

I understand that I may revoke authorization to the above listed individuals by notifying the PMRC staff. The individual's name will be removed from this release and documents in my medical record upon my request. To add to this list, I understand this must be done by me and in person at PMRC to prevent a misunderstanding from a possible fraudulent phone call.

Printed Name of Patient:_____

Signature of Patient:_____

Date:_____

(**Staff Alert:** Refer to the most recent authorization form when looking for release of information)