



**The Pain Medicine and Rehabilitation Center**  
1442 Horn Street, Suite A, Clarksville, IN 47129  
Ph 812-523-3700/ Fax 812-524-2946

**Authorization Release of Health Information**

I \_\_\_\_\_ 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 members or friends 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)**