TELEPHONE COMMUNICATION RELEASE OF INFORMATION

Due to HIPAA requirements, our office is not allowed to discuss your health information without your permission. Please write the names of people we are allowed to speak with about your care. (This does not include other physicians.)

NAME	RELATIONSHIP
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____

May we leave a message on your answering machine or voicemail? YES NO

If you circled yes, please specify what information:

□ Appointments □ Test/Lab Results □ Medication information
□ Other:_____ □ All information

May we call you at work? YES NO Work #_____
Home #_____ Cell # _____

You have the right to change any of this information at any time. *Please be advised that this authorization will expire one year from the date you sign it.*

_____ _____
Patient Name (please print) Date of Birth

_____ _____
Patient Signature **Date**

_____ _____
Signature of Parent or Guardian Date

MIDWEST REHABILITATION, P.A.

634 SW Mulvane, Suite 401
Topeka, KS 66606
785-357-6300
785-357-6324 F