First Coast
REHABILITATION
where patient care comes first

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO OTHER PERSONS AND/OR LEAVE MESSAGES

It is the policy of First Coast Physical Rehabilitation to not release confidential patient information about you unless it is for patient care and treatment, payment or operations. If you wish for our therapist and/or office staff to leave messages for you on your home telephone answering machine, work telephone, voicemail, cell phone or pager, or to any other person, then you must complete the following?

I authorize First Coast Physical Rehabilitation to release confidential patient information about me by the following methods and agree it is my responsibility for notifying my therapist or office staff whenever I want this to change:

We can fax copies of information to other offices if necessary	Yes _____	No _____
We can call your home	Yes _____	No _____
We can leave messages on your home phone answering machine	Yes _____	No _____
We can call you at work	Yes _____	No _____
We can leave a message on your voice mail	Yes _____	No _____
We can call your cell phone	Yes _____	No _____
We can page you	Yes _____	No _____

Email: ____

If you wish us to release confidential information on your behalf, please list the names of the parties below and their relationship to you.

Name	Relationship (i.e. Spouse, Parent, Friend, Therapist, Self)

______________________________ ______________________________

Patient Name Date

______________________________ ______________________________

Patient Signature/Legal Representative Witness Signature