Pain Care Physicians

Contact Numbers

Patient Name: _____
DOB_____/_____/_____

When necessary for us to contact you regarding health information, please indicate (in order of preference) the phone numbers we may use. Please check yes or no, if we can leave a detailed voicemail with medical information.

1. _____ home/work/cell Voicemail? ☐ Yes ☐ No
2. _____ home/work/cell Voicemail? ☐ Yes ☐ No
3. _____ home/work/cell Voicemail? ☐ Yes ☐ No

HIPAA Privacy Authorization Form

I, hereby authorize Pain Care Physicians to release any and all medical information and test results that pertain to me, to the following individuals.

Name:_____Phone #:_____Relation:_____

Name:_____Phone #:_____Relation:_____

Name:_____Phone #:_____Relation:_____

I authorize Pain Care Physicians to contact the individual(s) listed above to convey any pertinent information to me, in the event that I am unable to be reached by the facility.

I understand that I may revoke/cancel this authorization by notifying Pain Care Physicians in writing of my intent to revoke authorization or change the name(s) of the individuals to whom information is to be released.

_____ _____
Signature of Patient Date