Comprehensive rehab

Dedicated to improving our patients' lives

INFORMATION RELEASE FORM

PATIENT NAME_____**BIRTH DATE**_____
PARENT OR GUARDIAN_____
ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____
PHONE (HOME)_____**(WORK)**_____

I hereby give **COMPREHENSIVE REHAB** permission to **receive** and **release** all **information** to/from the following individuals / groups / agencies / organizations regarding this patient.
(Please **check** and **name / list all** that apply.)

☐ Physician(s)_____

☐ School(s)_____

☐ AEA 9_____

☐ University of Iowa Hospitals & Clinics_____

☐ Community Services_____

☐ Department of Human Services_____

☐ County Case Management_____

☐ Other_____

☐ Other_____

☐ Other_____

In the event we need to contact you, at what phone number(s) can you be reached?
1._____ - _____ - _____ May we leave a message? Y N Whose #?_____

2._____ - _____ - _____ May we leave a message Y N Whose #?_____

3. _____ - _____ - _____ May we leave a message Y N Whose #?_____
When leaving a message for you at any of the above listed numbers, is there information that you would **not want left** on the recorder? (For example: Name of our clinic, person calling, reason for call, patient's name, appointment times, insurance information, etc.)
___ **NO.** There are **NO restrictions**. Any necessary information may be given to the person answering the phone or left on the answering machine or voicemail..
___ **YES.** There **ARE restrictions**. **Please specifically list all restrictions and instructions that apply when our staff is trying to contact you.** _____
_____
_____

AUTHORIZED SIGNATURE:_____Relationship to patient:_____

Date:_____

PUBLIC RELEASE

I hereby **give my permission** to have _____'s likeness photographed or video taped and utilized by **COMPREHENSIVE REHAB** for educational and / or marketing purposes.

AUTHORIZED SIGNATURE:_____Relationship to patient:_____

Date:_____
I hereby **give my permission** to use _____'s first name and last initial to be used by **COMPREHENSIVE REHAB** to identify accomplishments, birthdays, etc.

AUTHORIZED SIGNATURE:_____relationship to patient:_____

Date:_____