FLOYD
OUTPATIENT REHABILITATION SERVICES

HIPAA AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient: _____ Phone Number: _____

Date of Birth: _____

If you would like this office or any provider who is a member of the Floyd Outpatient Rehabilitation Services to be able to discuss your medical care with someone other than yourself, please list the names of the individuals below.

Name: _____ Phone Number: _____

Relationship to patient: _____

Name: _____ Phone Number: _____

Relationship to patient: _____

Name: _____ Phone Number: _____

Relationship to patient: _____

Name: _____ Phone Number: _____

Relationship to patient: _____

Please be aware that you may add or delete names at any time with written notice to this office.

Signature of patient: _____

Date: _____