Complete Pulmonary Rehab

190 Aviation Plaza | Hot Springs, AR 71913 | 501.525.2770

Release of Information

_____ _____

Patient Name Date of Birth

Information Requested

I hereby authorize Complete Pulmonary Rehab to release or obtain information contained in my medical records.

I authorize the release of the information requested relating to my general medical treatment and/or any treatment. I further authorize the information to be faxed or electronically sent. I understand this authorization may be revoked at any time, providing the information has not already been disclosed. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I also understand that once the above information has been disclosed per my instruction, the information may no longer be protected by the confidentiality laws.

I hereby state that I have read and fully understand the above statements.

_____ _____

Patient/Legal Representative Signature Date