In Motion Physical Therapy & Sports Performance

Personal Representative/Medical Records Request

I, _____ , authorize Bon Secours Outpatient Rehabilitation Services to release information about my medical care to:

_____ _____
(Relationship)

_____ _____
(Relationship)

I understand that I must notify Bon Secours Outpatient Rehabilitation Services in writing in order to terminate this designation. I also understand that Bon Secours Outpatient Rehabilitation Services is not responsible for information that is re-disclosed by the above named individual(s).

_____ _____
(Patient's signature) (Date)

Patient Contact Request

I wish to be contacted in the following manner (check all that apply):

□ **Home Telephone** _____
□ Leave message with detailed information
□ Leave message with call back # only

□ **Written Communication**
□ Okay to mail to home address
□ Okay to mail to work/office address

□ **Work Telephone** _____
□ Leave message with detailed information
□ Leave message with call back # only

□ **Other**: _____
_____
_____

□ E-mail _____