BON SECOURS inmotion

# Bon Secours In Motion Physical Therapy

## 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

☐ **Work Telephone** _____
- ○ Leave message with detailed information
- ○ Leave message with call back # only

☐ E-mail _____

☐ **Written Communication**
- ○ Okay to mail to home address
- ○ Okay to mail to work/office address

☐ **Other**: _____
_____
_____