

AZ Pain Management & Rehabilitation
Estelle R Farrell D.O.

INSTRUCTIONS FOR RELEASE OF PERSONAL HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

I, _____ acknowledge that I have seen and read AZ Pain Management & Rehabilitations privacy practices.

I give permission to AZPM&R to communicate messages regarding my healthcare, medications appointments, referrals, labs and x-ray results and other tests as follows: (please check all that apply)

You may leave a message on my home and/or cell phone voicemail

You may leave a message and/or speak with _____

You may **NOT** communicate my health care information with _____

I have a POA (power of attorney) and will give the office a copy.

Patients Signature

Date