SportWorks
Rehabilitation Center

275 WEST BASSET ROAD, SUITE 1, SHELBYVILLE, INDIANA 46176 • 317-392-5855 / FAX 317-398-1871

AUTHORIZATION to DISCLOSE HEALTH INFORMATION

I,____, give my consent for SportWorks Rehabilitation Center to release medical and billing information to the following person(s):

Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:
Name:	Relationship to Patient:

I also understand that it is my responsibility to notify SportWorks Rehabilitation Center of any changes to this authorization. **This authorization is valid indefinitely unless we receive written notification of requested changes.**

I give SportWorks Rehabilitation Center permission to leave messages regarding my test results, appointment reminders, and any other information pertaining to my medical record on/with:

☐ Voice Mail ☐ Answering Machine ☐ Family Member ☐ Other

Signature of Patient, Parent, or Legal Guardian **Date**

Printed Name of Patient, Parent, or Legal Guardian **Date**

Signature of Witness SportWorks **Date**