PMC | URGENT CARE
& OCCUPATIONAL MEDICINE
Patient First. Quality Care.

311 E. Clifty Drive

Madison, IN 47250

812-274-2742

Medical Information Release Form

Patient Name: _____ **Date of Birth:** _____/____/_____

Release of Information

☐ I authorize the release of information including the diagnosis, records, examinations rendered to me, and claims information.

This information may be released to:

- ☐ Spouse_____
- ☐ Parent(s)_____
- ☐ Child(ren)_____
- ☐ Other_____
- ☐ Information is not to be released to anyone.

This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my cell Number:_____

If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave a message asking me to return your call

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____