THE REHABILITATION CENTER
WATAUGA MEDICAL CENTER
Member of Appalachian Regional Healthcare System

Label
Name: _____
DOB: _____

Release of Medical Information

Name_____ DOB _____ Date last signed: _____

Persons authorized to receive information

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

Please indicate information that can be released	**How may we leave messages for you?**
☐ Medical (i.e. results of lab tests / x-rays) ☐ Appointment information ☐ Financial ☐ Other	☐ Voice mail _____ ☐ Email_____ ☐ Other_____ _____

Signature Page

- All of my registration information is true and accurate to the best of my knowledge
- I acknowledge that I received the Release of Medical Information and the Financial Information I understand that I have the right to revoke this authorization at anytime. Revocation must be made in writing and will be effective from date of revocation.
- I have read/received a copy of Patient Rights and Responsibilities.
- I understand that because The Rehabilitation Center is owned by Watauga Medical Center, all PT, OT and SLP services will be billed as a "facility". As a hospital-based facility, insurance companies view us differently than other outpatient rehabilitation providers. You will be responsible for the percentage of your bill not covered by your insurance policy (deductible and co-insurance). Because we bill as a facility, co-pays rarely apply.

_____

Signature of Patient / Legal Guardian *Date*

_____

Signature of Guarantor (if applicable) *Date*

_____

Description of Personal Representative's Authority (attach necessary documentation)