CENTRAL STATES
PAIN CLINIC℠
INNOVATIVE PERSONAL CARE

Office: (515) 267-1819
Fax: (515) 457-9180

1300 37th Street, Suite 3
West Des Moines, IA 50266

Limited Authorization and Release of Information Form

Patient Name:_____Date of Birth:_____Date:_____

How do you want to be addressed when summoned from the reception area?

☐ First name only ☐ Proper surname ☐ Other:_____

Please list any other parties who can have access to your health information:
(This includes step parent, grandparents, and any care takers who can have access to this patient's records.)

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Please list any other doctors, medical clinics, and healthcare providers who can have access to your health information:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I authorize contact from this office to confirm my appointment, treatment, and billing information via:

☐ Cell phone confirmation ☐ Text message to my cell phone ☐ email confirmation
☐ Home phone confirmation ☐ Work phone confirmation ☐ Any of the above

I authorize information about by health to conveyed via:

☐ Cell phone confirmation ☐ Text message to my cell phone ☐ email confirmation
☐ Home phone confirmation ☐ Work phone confirmation ☐ Any of the above

Signature:_____Date:_____