ARUL DORAISWAMY, MD, APC
Hemet Pain & Wellness Institute

1264 East Latham Ave, Hemet California 92543
28975 Old Town Front Street Suite #200, Temecula CA 92590
Phone (951)925-3600 • Fax (888) 491-6419

Medical Information Release Form

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

Release of Medical and Insurance Information:

[ ] I authorize the release of any and all of my medical information (including insurance and claims information) to the following people:

[ ] Spouse_____

[ ] Children_____

[ ] Other_____

[ ] My medical information is not to be released to anyone.

The above designations will remain in effect until terminated by me in writing.

Messages:

To contact me, please call the following [ ]home [ ]work or [ ]cell phone number:

_____
If unable to reach me:
[ ] please leave a detailed message on the above number.
[ ] please leave a message on the above number, asking for a return call.
[ ] _____

The best days/times to reach me during the week are: _____

Patient Signature: _____ Date: ____/____/_____

Witness Signature: _____ Date: ____/____/_____