



Privacy Disclosure

If you would like us to contact your Doctor with any updates and reports of your current condition, please provide the name of your Physician.

Doctor: _____

Address: _____

City, State: _____

Telephone: _____

* I have received a copy of the "Notice of Privacy Practices" provided to me by Capitol Rehab of Winchester, PLLC.

Printed Name: _____

Signature: _____

Date: _____