DLT Department of Labor and Training
RHODE ISLAND

ARRIGAN REHABILITATION CENTER RECORD REQUEST

& CHANGE OF INFORMATION

Please PRINT ALL INFORMATION

NAME: _____ SS#: _____ AC#: _____

ADDRESS: _____

STREET APT# CITY/TOWN STATE ZIP

HOME PHONE#: _____ CELL#: _____ EMAIL: _____

Describe recipient(s) listed below by checking off one or more of these boxes:

☐ Self ☐ Attorney ☐ Doctor ☐ Case Manager ☐ Other

List name, address, and phone # of individual(s) you have checked, excluding yourself, unless your mailing address is different than above.

NAME ADDRESS PHONE#

_____

_____

_____

_____

_____

Which reports are you requesting?

☐ All reports generated by Arrigan Center

☐ Physical therapy reports only

☐ Vocational Reports only

☐ Specific reports_____

☐ Other_____

List name and address of person(s) you are removing from recipient of records:

_____

_____

_____

_____ _____

Patients Signature Date Witness Signature Date