

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name: _____ Date of Birth: _____
Phone: H) _____ Phone: W) _____
Address: _____ City/ State/ Zip: _____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: _____ Facility Phone: _____
Facility Address: _____ Facility Fax: _____
City, ST, Zip: _____

Dates and Type of information to disclose:

- 2 years prior from last date seen
- Dates Other: _____
- Specific Information Requested: _____

The purpose of disclosure is:

- Change of Insurance or Physician
- Continuation of Care
- Referral
- Other: _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

This information may be disclosed and used by the following individual or organization:

Release To: _____ Freedom Mobility Center, LLC
Address: _____ 586 Parker Avenue
City, State, Zip: _____ Rodeo, CA 94572 Please mail records.
Fax: _____ Phone: _____ Please fax records.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. **Unless otherwise revoked, this authorization will expire on the following date, event, or condition:** _____
If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X _____
Signature of Patient / Parent / Guardian or Authorized Representative
(Guardian or Authorized Representative must attach documentation of such status.)

Date

Printed name of Authorized Representative

Relationship / Capacity to patient

Address and telephone number of authorized representative