Alpha Rehabilitation, P.C.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBER(S), GUARDIAN, AND OTHERS

First & Last Name of Patient: _____

Date of Birth: _____

I hereby authorize medical providers and personnel of Alpha Rehabilitation, P.C. to discuss and/or release my protected health information with: (Please note that if the patient is a minor, each parent or guardian needs to be listed.)

Name: _____ Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law. I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Relationship to Patient