PARAMOUNT
Rehabilitation Services

AUTHORIZATION FOR RELEASE OF INFORMATION

INFORMED AUTHORIZATION/CONSENT FOR THE RELEASE OF MEDICAL RECORDS: I hereby authorize: PARAMOUNT REHABILITATION SERVICES to release/obtain the medical records of:

Patient Name: _____ Date of Birth: _____

Release information to the person (s) listed below:

_____

_____

_____

Obtain information from person (s) listed below:

_____

_____

_____

Please check (X) what is specifically to be released:

( ) Medical Records ( ) Phone Conversation ( ) Other-specify below

_____

I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity (ies) as stated above. This authorization will remain in effect for a period of one year from the date signed below unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian, or legally authorized agent) to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable Michigan State and Federal Law.

Patient
Signature: _____ Date: _____

Parent/Guardian
Signature: _____ Date: _____

Witness: _____ Date: _____

SUBMIT