Rehabilities

Authorization to Release Medical Records

Patient Name: ______________________________ DOB: ________________ Age: _______

Address: ____

City: ______________________________ State:____________ Zip Code: _____________

I hereby authorize ________________________________ to provide a copy, summary or a narrative of my medical records as indicated below:

- ❑ Complete Records
- ❑ Radiological Reports
- ❑ Records of care concerning the following conditions:
  ____
  ____
  ____

Release to the following:

Rehabilities
1208 McRae Blvd
El Paso, Texas 79925
(915) 595-4500
Fax (915) 595-4502

This authorization extends to copies of any and all records, reports, or other documents which you have generated pertaining to any treatment and/or service rendered to the undersigned. The information requested includes but is not limited to chart notes, reports, written reports, x-rays, tests, MRI's, EMG's, CT scans, drug administration records, hospital records, pharmacy records, and any other data pertaining to undersigned's physical, medical, and any other health related information concerning the above stated patient.

I understand that you will provide this information within a reasonable period of time.

____ ____________________
Patient Signature Date

____ ____________________
Witness Date