AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ SS#: ____-____-____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: _____ EVENING PHONE: _____

I hereby authorize _____ **to release information from any**
Name of Doctor or Hospital
medical record as indicated below to:

NAME: FirstCare Rehabilitation, Inc
ADDRESS: 1725 S. Hwy 183 #100./P.O. Box 334 CITY: Clinton STATE: Okla. ZIP: 73601
PHONE: (580) 323-1682 FAX: (580) 323-1711

INFORMATION TO BE RELEASED:

		DATES:
☐	History and physical Exam	_____
☐	Progress notes	_____
☐	Lab reports	_____
☐	X-ray reports	_____
☐	Other: _____	_____
	_____	_____

PURPOSE OF DISCLOSURE:
☐ Changing physicians ☐ Consultation/second opinion
☐ Continuing care ☐ Legal ☐ School
☐ Insurance ☐ Workers Compensation
☐ Other (please specify) _____

1. I understand that this authorization will expire 90 days after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by FirstCare Rehabilitation, Inc. for the purpose of: Continuing Care
   A. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   B. I understand I may see and obtain a copy of the information described on this form if I ask for it.
   C. I have been informed that FirstCare Rehabilitation, Inc. ☐ will/☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Oklahoma statue I may pay a fee up to $0.35/page. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT