Advance Rehab – Main Office

2316 W. 23rd Street
Panama City, FL 32405
850-522-4770 or 850-522-4760 FAX

INFORMATION RELEASE AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information to:

DR.: _____
DR.: _____
DR.: _____

Advance Rehab and Home Health LLC

Insurance Company: _____

Insurance Company: _____

For the following purposes:

*My injury and all progress and associated issues
*Billing and reimbursement issues

I understand the information outlined in this release will be disclosed to according to the instructions of the release within two (2) business days of **Advance Rehab** having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the **Privacy Regulations** (45 CFR 164).

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

_____ _____
Patient Signature Date