AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT IDENTIFICATION:

Patient Name: _____Date of Birth: _____

Address: _____

Phone #_____Social Security #: _____

PURPOSE OF DISCLOSURE:

Please check the purpose for which the information is being authorized for disclosure:

☐ At the request of the patient

☐ At the request of the patient's representative

ENTITY Authorized TO RELEASE Information: Zenith Rehabilitation LLC, 14500 E. 42nd St, Independence, MO

ENTITY Authorized TO RECEIVE Information:

Name: _____

Address: _____

Fax: ( )_____

Phone: ( )_____

DESCRIPTION OF HEALTH INFORMATION AUTHORIZED FOR RELEASE: [Check all that apply]

☐ Entire medical record (excludes records from other providers)

☐ Complete billing records/itemized bill

☐ Other (specify): _____

I AUTHORIZE THE RELEASE OF: (Check One)

☐ My medical records created before the date I signed this authorization

☐ My medical records created both before and after the date I signed this authorization

☐ My medical records created after the date I signed this authorization

☐ Specific Date(s) of Care or Diagnosis to be Released: _____

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PROTECTED HEALTH INFORMATION

THE PATIENT OR REPRESENTATIVE MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

- I understand that this authorization will expire 1 yr. from the date this ROI is signed. **Initials: _____**
- I understand that I may revoke this authorization any time by submitting a written notice at Zenith Rehabilitation LLC. **Initials: _____**
- I understand that if I do revoke this authorization, it will not have any effect on any actions taken before the receipt of the revocation. **Initials: _____**
- I understand that after this information is disclosed, Federal law might not protect it and the recipient may be required to re-disclose it. **Initials: _____**

SIGNATURE OF PATIENT OR REPRESENTATIVE WHO MAY REQUEST DISCLOSURE:

Treatment will *not* be denied if authorization is not given, however future treatment(s) may be delayed due to restricted flow of information. The patient or representative can review or copy protected health information to be used or disclosed. If medical records or correspondence from other providers is released pursuant to this form, we cannot attest to the accuracy or completeness of that information.

I HEREBY AUTHORIZE ZENITH REHABILITATION LLC TO RELEASE PROTECTED HEALTH INFORMATION AS SPECIFIED ABOVE:

_____ _____

Signature of patient/representative **Date:**

_____ _____

Print name of patient or representative **Relationship of Person Signing**

Identity of requester verified via: ____Photo ID_____Matching Signature____Other Verified by Initials: _____