Rehab Professionals of Cleveland, Inc.

Broadview Heights
7000 Town Centre Drive
Suite 400
Broadview Hts.,Ohio 44147
440-526-8566
Fax: 440-546-8280

Lakewood
12221 Madison Ave.
Lakewood, Ohio 44107
216-221-2525
Fax: 216-221-2506

Downtown Cleveland
The Galleria
at Erieview
1301 East Ninth Street
Cleveland, Ohio 44114
216-566-8566
Fax: 440-546-8280

North Olmsted
23887 Lorain Road
North Olmsted, Ohio 44070
440-777-1764
Fax: 440-777-1321

AUTHORIZATION TO RELEASE INFORMATION

Patient name:_____ SS: _____ DOB:_____

I consent to and request that Rehab Professionals of Cleveland, Inc. (check one or both)

[ ] Release to

[ ] Obtain from

_____

Agency and/or individual

_____

Phone Number Fax

_____

Address City State Zip code

Purpose of Disclosure:_____

Information to be Released [ ] or Obtained [ ]

[ ] Itemized statement Dates of service: From: _____To: _____

[ ] Progress Notes [ ] Other information_____

[ ] Discharge summary

[ ] Entire medical record

I hereby waive confidentiality rights to the above named party or parties, as specified. I authorize release of this Information, and hold Rehab Professionals of Cleveland, Inc. harmless from all legal liabilities or responsibilities, which may arise from this act. I understand that any Information released cannot be retrieved, and Rehab Professionals of Cleveland, Inc. will not be held responsible for such. I understand and acknowledge that the medical record may contain mental health/alcohol/drug abuse information and I expressly consent to the release of such information. I also understand that personal health information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and is no longer protected by state or federal law or regulations.

This authorization for release of Information is valid for one year from the date of the signature, unless revoked by written notice to the providing institution, providing said notice is received prior to release of the Information. I understand that there may be charges associated with this request that are owned by me and which are due.

_____ _____

Patient signature (parent or guardian if minor) Date

_____ _____

Name printed If not patient: relationship

_____ _____

Witness signature Date

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED THIS AUTHORIZATION AND AGREE TO TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR THE PURPOSE SET FORTH WITHIN THIS AUTHORIZATION

5/24/2013