Authorization for Release of Protected Health Information

I, _____, do hereby authorize Morganstein De Falcis Rehabilitation Institute to:
(Print Patient's Name)

disclose to/receive from _____
(please circle one) (Facility Name)

_____
Facility Address State Zip

information regarding my medical record(s), including photocopies, relating to my identity, diagnosis, prognosis, and for treatment including:

- ☐ All Records
- ☐ Specify requested portions of records:

_____

_____
(Specify Dates of Treatment)

The purpose of disclosing the above information is indicated by a check mark ( ) below:

☐ Continuing Care ☐ Insurance ☐ Legal ☐ Other (please specify)_____

I understand that I am releasing to the person/organization identified above, information which is specially protected under provisions of state and/or federal law. I further understand that I may revoke, in writing, this authorization at any time except to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. This authorization includes the release of information about the following, if included in the medical record: AIDS, HIV-related information or testing, psychiatric disorders, drug treatment and/or alcohol treatment. (Delete those records, if any, which are not to be released.) If not revoked earlier, this consent will remain in force for 12 months unless otherwise specified by the patient.

_____	_____	_____
Signature of Patient	Patient's Date of Birth	Date
_____	_____	_____
Signature of Personal Representative (if applicable)	Relationship to Patient	Date
_____	_____	
Witness Signature	Date	