AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
TO ALLIED REHABILITATION SERVICES (Allied Rehab)

_____	_____
(Print Patient's Full Name)	**Birth Date (Mo/Day/Year)**
_____	_____
(Street Address)	**(Social Security Number)**
_____	_____
(City, State, Zip Code)	**(Phone #)**

RELEASE THE FOLLOWING:

_____
_____
_____

From the treatment period of _____ to _____

_____ I Do _____ I DO NOT authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
_____ I Do_____ I DO NOT authorize release of information related to Psychiatric care and/or psychological assessment, and treatment for alcohol or drug abuse.

INFORMATION RELEASE TO: **Allied Rehabilitation Services**
900 S Franklin St, Suite 201
Wake Forest, NC, 27587
PHONE: 919-556-1700 x 2
FAX: 919-556-1245

PURPOSE OF DISCLOSURE

_____Referral to Specialist _____Insurance _____ Workers Comp. _____ Change of Doctor
_____Legal Investigation _____Disability Determination _____Personal _____ Continuing care

Please provide daytime phone number in the event we need to contact you_____

I hereby authorize disclosure of the health information for above named patient. This authorization is valid for twelve (12) months from the date of signature. I understand that I may cancel this request with written notification but that will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations.

_____	_____
Signature of Requestor (Patient , Guardian or Personal representative of patient's state)	**Date**

If other than patient describe relationship: _____

***** Please note: There is a charge for medical records when requested, permanent transfer, insurance purposes, legal purposes or disability purposes. *****