MEDISYS
REHABILITATION, INC.

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HIPPA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

(Pursuant to 45 CFR 164.508)

TO:

____
Name of Healthcare Provider/Physician/Facility/Medicare Contractor

____
Street address, City, State, and Zip

RE:

______________________ ____________ ____________
Patient Name | Date of Birth | Social Security #

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a legal claim. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

- ☐ All medical records, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires, histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers.

- ☐ I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information. This authorization is given in compliance with the federal consent requirements for release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have been specifically considered and expressly waived.

☐ You are authorized to release the above records to any representative of:

MediSys Rehabilitation, Inc.
Life Care Planning Services
5524 Bee Caves Road, Suite A-1
Austin, Texas 78746
(512) 459-4315

I understand the following:

☐ I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this information.

☐ The information released in response to this authorization may be re-disclosed to other parties.

☐ My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of this authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until 2 years from date of
execution at which time this authorization expires.

____ _______________
Signature of Patient or Legally Authorized Representative Date

____
Name and Relationship of Legally Authorized Representative to Patient

____ _______________
Witness Signature Date