**Release of information:** I, hereby, authorize any hospital, TCU, physician’s office or other health agency where I have been a patient to disclose any part or all of my medical records, including any Health Care Directive to **Recover Care**. In addition, I authorize the release of part or all of my medical records to health care agencies and medical equipment vendors whose services may be required in conjunction with the services provided by **Recover Care**.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Signature of Patient/Legally Authorized Representative  |  | Date |

**Please send requested information to Recover Care at:**

* Fax #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Regarding the following client:**

|  |  |
| --- | --- |
| Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Requested Records:**

|  |  |
| --- | --- |
| * Discharge Summary
 | * Laboratory Report
 |
| * Emergency Room Report
 | * Pathology Report
 |
| * History & Physical
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Purpose of Release:**

|  |  |  |
| --- | --- | --- |
| * Continuing / Transfer of Care
 | * Insurance
 | * Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Recover Care Staff Date