AUTHORIZATION TO RELEASE MEDICAL INFORMATION
AND PROFESSIONAL CONSENT

TO:_____

CLIENT: **DOB:** **SSN:**

I hereby give consent to _____ to release, to an authorized representative of Medical Rehabilitation Consultants, Inc., all medical and billing information: Medical records, chart notes, radiology reports, consult reports, correspondence, and all laboratory tests performed on the above-named patient, for any purpose. **I further request that a copy of all such information be furnished to the duly-authorized agent/employee of Medical Rehabilitation Consultants, Inc. who is designated by Medical Rehabilitation Consultants, Inc. to receive this information.** I consider release of this information to Medical Rehabilitation Consultants, Inc. essential for the proper medical management of the above-named patient's case and disclosure by their agents justifiable.

I understand that my express consent is required for the release of information relating to sexually transmitted diseases, mental illness, psychiatric treatment, and/or drug/alcohol abuse and that to authorize disclosure relating to sexually-transmitted disease and HIV, a patient must have reached his/her fourteenth birthday. I give my specific authorization for these records to be released.

I further understand that the above-referenced facility cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release the above-referenced facility, its staff and Medical Rehabilitation Consultants, Inc. from all legal responsibility that may arise from the release of the medical information hereby authorized.

I give my permission for Medical Rehabilitation Consultants, Inc. to review, as deemed appropriate to determine vocational status and/or rehabilitation potential. I further authorize Medical Rehabilitation Consultants, Inc. to discuss information with other professionals involved in the above-named patient's treatment and rehabilitation and to recommend the appropriate interventions. I understand the information maybe subject to re-disclosure and may no longer be protected under federal law.

I understand the refusal to sign the authorization will not adversely affect my ability to receive health care services or reimbursement for services or adversely affect my enrollment in a health plan or eligibility for benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization at any time by notifying Medical Rehabilitation Consultants, Inc., in writing.

I agree that a photocopy of this consent be accepted if necessary.

_____ _____
Dated Patient Signature

IF MINOR, BY PARENT OR LEGAL GUARDIAN:

_____ _____
Dated Parent/Legal Guardian Signature

This authorization will expire in 90 days from the date signed.

111 W. Cataldo, Suite 200 * Spokane, Washington 99201-3203 * 509-328-9700