Pediatric Rehabilitation Specialists

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Last Name: _____

First Name: _____

Middle Name: _____

Patient Date-of-Birth _____

Patient Address: _____

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

1. Pediatric Rehabilitation Specialists LLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to provide care and communicate with other healthcare parties.

2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to Pediatric Rehabilitation Specialists LLC.

3. I have the right to revoke this authorization at any time by writing to Pediatric Rehabilitation Specialists LLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.

6. This authorization expires one year from the date of my signature below.

7. THIS AUTHORIZATION DOES NOT AUTHORIZE PEDIATRIC REHABILITATION SPECIALISTS LLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

_____ _____
Signature of patient or representative authorized by law Date

_____ _____
Relationship to Patient Interpreter, if used