Jeffrey Kahn, MD
Medical Director

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize **rehabwoRx Physical Medicine and Rehabilitation, PLLC** to release medical records and other data pertaining to the patient noted below:

Patient Name:	**Social Security#:**
Date of Birth:	**Phone Number:**
Street Address:	**City, State, Zip Code:**

Please specify what records should be released:

- ❑ All records including office notes and results of diagnostic studies
- ❑ Insurance demographic information with limited PHI
- ❑ All records between the dates of _____ and _____
- ❑ Records pertaining to _____
- ❑ Information regarding HIV/AIDS status or treatment
- ❑ Information regarding mental health status (neuropsychological testing or treatment)

Please specify method of release:

❑ Pick-up by patient	❑ Send by fax	❑ Hand delivery
❑ Certified Mail	❑ Send by standard mail	❑ Phone call

Individual or organization listed below is authorized to receive or release records as specified above:

Name:	**Title/Business:**
Street Address:	**City, State, Zip Code:**
Phone Number:	**Relationship to Patient:**

Patient Signature: _____ Date: _____

Internal Use Only:

Date Records Released: _____

Records Released By: _____