Custom Care Rehab, LLC
4175 Bellaire Lane
Peninsula Ohio
44264
Phone: 330-618-5703
Fax: 243-678-3387

Authorization for Release of Medical Information

Patient's Name:_____ Date of Birth:_____
Address:_____
City/State/Zip Code:
_____ Patient's Phone #: _____ Date of Request: _____
Date Needed:_____

I authorize Custom Care Rehab to release information to:
_____ Name of Provider Facility
_____ Address
_____ City, State, Zip Code
_____ Phone # / Fax # (Including Area Code)

I authorize Custom Care Rehab, LLCC to obtain information from:
_____ Name of Provider Facility
_____ Address
_____ City, State, Zip Code
_____ Phone # / Fax # (Including Area Code)

PURPOSE FOR THIS REQUEST: (Check one) Test results Diagnostics Other (Specify) _____ TYPE OF RECORDS REQUESTED: (Check one) All medical records; or I only want parts of my medical record, described below, to be disclosed:

_____
_____
_____
_____

AUTHORIZATION VALID FOR: (Check one) This request only. One year from date of this authorization OR _____ (Insert date) This Authorization Applies to the records of the treatment received on or prior to the date of the authorization. This request and for medical records of any future treatment of the type described above until: _____ (Insert Date)

Signature of Patient or Representative:
_____Date:_____
Relationship to Patient (if requester is not the patient)
_____