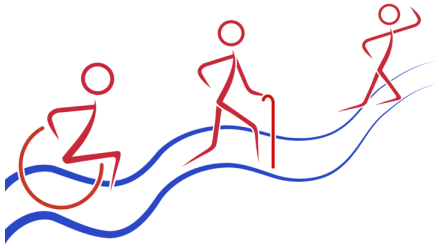
Grand River Rehabilitation

Serving adults & children with pain & disabilities



Patient Name: _____ Date of Birth: _____

Release of Information

I authorize:

Grand River Rehabilitation, LLC
Dr. AJ Rush
412 Plymouth Ave NE
Grand Rapids MI 49505
616-780-2324/616-431-2407

To release/exchange with:

Organization/Facility _____
Physician/Provider _____
Address _____
_____
Phone/Fax _____

Information to be released:

- ☐ Entire chart
- ☐ Other (please list): _____

Purpose of disclosure (check all that apply):

- ☐ Continued medical care
- ☐ Insurance
- ☐ Other: _____
- ☐ Personal
- ☐ Legal

I understand that this authorization will automatically expire in one year or once the purpose for which it was signed is accomplished. The Protected Health Information disclosed under this authorization may be subject to re-disclosure by the recipient, and the law will no longer protect the privacy of my Protected Health information. I understand that I may revoke this authorization in writing at any time except to the extent that action has already been taken. I acknowledge that Grand River Rehabilitation, LLC will use or disclose my Protected Health Information in reliance upon this authorization. I understand that a reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication. The requestor may be provided with a copy of this authorization. By signing this authorization, I acknowledge that I have read and understand this authorization and I authorize the use or disclosure of my Protected Health Information is in accordance with the terms of this authorization.

_____ _____

Patient/representative signature | Date

_____ _____

Printed name | Relationship to patient