REJUVENANCE THERAPY
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

Date of Birth: _____

_____
(Name of Patient – Printed)

Information to be Released **to**:

_____
(Name of Patient or Facility or Designated Person)

Information to be released **From**:

REJUVENANCE THERAPY
SARAH DIBLE PT
300 East 24th St
Vancouver, WA 98663
Phone: 360-798-7625
FAX: 360-553-4165

_____
(Street Address)

_____
(City, State, Zip code)

_____
(Phone/or Fax Number)

Information to be released:

Initial in space below indicating that you authorize the disclosure of the following health information and records.

_____ Chart Records between the dates of _____ to _____.

_____ All Chart Records to date.

_____ Billing Records.

Purpose for which request is being made:

☐ Medical ☐ Insurance ☐ Legal ☐ Personal ☐ Other _____ (specify)

Patient Authorization:

I understand that I may cancel or revoke this authorization at any time with the exception of action that may have been taken up to the point of revocation in reliance upon this authorization. If I cancel my authorization the information above may no longer be used or disclosed for any purpose. Unless revoked, this authorization expires in 90 days from the date of signature. To change or revoke this authorization send a written notice to Rejuvenance Therapy, 300 East 24th St. Vancouver, WA 98663 or fax it to 360-553-4165.

Signature: _____
(Patient signature/Legal Representative or Legal Guardian)

Printed Name: _____ Date: _____

Relationship to Patient of Legal Representative or Guardian: _____