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Authorization to Release and/or Receive Healthcare Information

Name: _____ Date of Birth: _____

Address: _____

I request and authorize Encompass Care, LLC to release and/or receive healthcare information:

_____
Name of Health Care Provider/Agency/Individual

_____
Address and Phone/Fax

Information requested:

☐ Medical history and physical	☐ Social History	☐ Medication Information	☐ Communication
☐ Psychological evaluation	☐ Treatment Plan	☐ Academic Records	☐ Entire Record
☐ Psychiatric evaluation	☐ Discharge Summary	☐ Hospital Records	☐ Lab Reports

Information may be used for evaluation, treatment, educational planning, follow-up, continuity of care or for further medical treatment. This authorization is good for one year from the date signed or for _____ days. I have reviewed this authorization form and confirm that it reflects my wishes to release/receive protected healthcare information. I understand that any disclosure of information carries with the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. By signing this document, I release Encompass Care, LLC from any liability resulting from this disclosure. I also have the right to revoke this authorization at any time and must do so in writing to the office manager at Encompass Care, LLC. I further understand that actions already taken based on this authorization, prior to revocation, will not be affected. A photocopy or fax of this document shall have the same effect as the original copy.

_____
Signature of Patient/Legal Representative

_____
Date document signed

_____
Encompass Care Representative