GEORGIA REHABILITATION SPECIALISTS, LLC

1438 Suite C Hwy 16 West
Griffin, GA 30223
Phone: (770) 467-4426 Fax: (770) 467-4427

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: ______________________________________ Date of Birth: ____________________________
Previous Name: ______________________________________ Social Security #: _________________________

I request and authorize Georgia Rehabilitation Specialists, LLC to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: State: Zip Code: ____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________________

____

☐ All healthcare information

☐ Other: ____

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____ ______________________________
Patient Signature: Date Signed:

THIS AUTHORIZATION DOES NOT EXPIRE UNLESS A WRITTEN REQUEST IS RECEIVED.

Medical Record Number ___________________