YPSILANTI REHABILITATION SERVICES
AUTHORIZATION TO RELEASE INFORMATION

Under l'vfichigan and Federal law, no information, which may have been obtained in a professional capacity, may be disclosed without the consent of the patient or legal guardian. Before Ypsilanti Rehabilitation can complete your request for protected health information, we must first verify and document your identity, the information you would like to use or disclose and your purpose(s) in requesting this information. Your signature on the Release of Information Form must be witnessed.

Patient Name:_____ Birthdate: _____

Address _____ Phone#_____

City, State, Zip Code _____ Chart# _____

Provide To___ /Release From X
Ypsilanti Rehabilitation Services
2063 Rawsonville Road
Belleville, MI 48111
(734) 485-4544

Provide To /Release From
_____
_____
_____
_____

I authorize the release **to** Ypsilanti Rehabilitation Services, the following information to be used and/or disclosed: _____

_____

For the purpose of: _____

I authorize the release of information **from** Ypsilanti Rehabilitation Services, the following information to be used and/or disclosed:

_____

For the purpose of: _____

This authorization is valid through (date or event) _____

I understand that I have the right to revoke this authorization at any time. I also understand that the revocation must be in writing and revocation is not valid until signature is received.

Patient Signature:_____ Date: _____

Signature of Legal Guardian: _____ Date: _____