5934 U.S. Hwy 6
Portage Commons
Portage, Indiana 46368
Ph. (219) 762-7136
Fax (219) 762-5148

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize Rohe Therapy, Inc. to review or receive a copy of medical record and any information contained therein, whether audio taped, saved on computer disc or any other means of storing and /or exchanging medical information. My release includes information, which pertains to:

____
(information to be released)

Name of Patient ____

Date of Birth ______________________________

Social Security # ______________________________
(For use by the provider of information to locate records)

Address ____
(Street)

____
(City) (State) (Zip)

- I understand that I may revoke this authorization to release medical records to the above named Person (s) in writing at any time. I understand that my records are protected under federal and state confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been takin in reliance thereon. A general authorization for release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse patient.

Patient's Signature ______________________________ Date ______________