Phone: 703-383-1616
Fax: 703-383-1166
receptionist@excelrehabva.com

Authorization Release Medical Information

Patient Name: _____ **Date of Birth:** _____

I, _____, herby authorize Excel Rehabilitation, the release of my medical records/information (examination/treatment records, diagnoses, billing statements and billing documentation)

Medical Information Requested:

- Itemized Bills + Statements
- All Medical Records
- Specific Records - **Injury / Area of Treatment** _____

  Visits From: _____ to _____

This information may be released to:

- **Self:** _____
- **Spouse:** _____
- **Children:** _____
- **Other:** _____
- **Information is NOT to be released to anyone.**

Purpose of Disclosure:

- Changing facility / physician
- Legal
- Workman's Compensation
- Other: _____

I am requesting and authorize the release of my medical records to be sent via:

Mail: _____

Fax: _____ Email: _____

By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Name: _____ **Date:** _____