Covell Care & Rehabilitation

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO COVELL CARE AND REHABILITATION, LLC

I hereby authorize the person, agency or organization named herein to release any and all information pertaining to my care to Covell Care and Rehabilitation, LLC.

Filled out by Covell Care representative:

1. _____
2. _____
3. _____
4. _____

The following is requested in regards to my care:

Check only those that apply:

____ History and Physical
____ Recent Visit Summaries
____ Discharge Summaries
____ Height and Weight
____ Current Medications
____ PT/OT/SLP Evaluations and Notes
____ Neurological Consultation
____ Neuroimaging Results including CT Scans and/or MRI
____ Copies of insurance cards and photo ID
____ Other: _____

Client Name: _____ **Date of Birth**: _____

_____ _____

Client/Legal Guardian/POA/Client Representative Signature **Date**