AUTHORIZATION FOR MUTUAL EXCHANGE OF INFORMATION

Date of Request:____

Regarding (Patient):____

DOB:_____________________________Medical Record #:_____________________________

SSN #:_____________________________

I do hereby authorize the mutual exchange of information between **ProCare Home Medical** and

____

(Name of Doctor or Clinic)

I Understand that this information is necessary to assist ProCare Home Medical in billing my insurance for services and that all practices of confidentiality will be followed in the use of the information gathered. I also understand that this release is valid for one year after the date it is signed unless otherwise notified.

This authorization covers the following types of information:

___Admission History & Physical (Admission Date:_____________________)

___Discharge Summary

___Sleep Study Results

___Other, ____

__ Photographs – *I agree to allow Procare Home Medical to take, reproduce and use photos, video tape, video monitoring/recording, or audio recording for the purpose of diagnosis, testing medical evaluation, care or treatment, patient safety or medical education, and to preserve clinical information. I understand that this material may ne treated as part of my medical record and that Procare Home Medical Inc., privacy policies apply.*

____

Patient Signature Relationship

____

Patient Name (Printed) Date Signed

Please Fax the requested information to the Fax number below, or mail to the following address:

ProCare Home Medical, Inc.
4215 Credit Union Drive
Anchorage, AK 99503
PH: (907) 274-0770 FAX: (907) 274-0773