



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, _____

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