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 send the requested information either to the fax number, email, or mail below to your branch location:

Email: dme@procarehm.com

Anchorage	**Fairbanks**	**Soldotna**	**Wasilla**
4215 Credit Union Drive	915 30th Ave Suite 106	35563 Kenai Spur Hwy	901 N Leatherleaf Loop
Anchorage, AK 99503	Fairbanks, AK 99701	Soldotna, AK 99669	Wasilla, AK 99654
Phone:(907) 274-0770	Phone: 907-458-8912	Phone: 907-260-4433	Phone: 907-357-7882
Fax: (907) 274-0773	Fax: 907-458-8914	Fax: 907-260-3757	Fax: 907-357-7883