Health Information Service
6410 Rockledge Drive,# 600, Bethesda, MD 20817
Phone: (301) 581-8091 Fax: (301) 581-8083

MedStar National Rehabilitation Network

Release of Information Authorization

1. PATIENT NAME (LAST-FIRST-MIDDLE)	2. PREVIOUS LAST NAME (IF APPLICABLE)	
3. STREET ADDRESS:	4. CITY,STATE	5. ZIP
6. TELEPHONE NUMBER	7. BIRTHDAY	8. SOCIAL SECURITY NO.

8. I authorize the release of the following information (check all applicable)

	Inpatient		Outpatient
	Entire Chart		Entire Chart
	Discharge Summary		Physician/Clinic Evaluations
	History and Physical		Therapy and Discharge Evaluations
	Team Conference		☐ PT ☐ OT ☐ SLP ☐ VOC ☐ Rehab Eng ☐ CC
	Therapy and Discharge Evaluations		Radiology
	☐ PT ☐ OT ☐ SLP ☐ VOC ☐ Rehab Eng ☐ CC		Labs
	Radiology		Psychology Evaluations and Discharge Reports
	Labs		
	Psychology Evaluations and Discharge Reports		

10. Please release my medical records to:

Name:	John E Toerge, DO
Address:	5410 Edson Lane, Suite 350; Rockville, MD 20852
Phone:	Phone: 301-377-2661
Fax:	Fax: 240-765-6340
Name:	
Address:	
Phone:	
Fax:	

I give permission to use and disclose protected health information as indicated above. I understand that I may cancel this authorization at any time by notifying MedStar National Rehabilitation Network's Health Information Services Department in writing and my cancellation will take effect when MedStar National Rehabilitation Network's Health Information Services Department receives my written notice. I understand that when the Health Information Services Department discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information. I understand that this authorization will take effect on the date signed and will be in effect until canceled by me in writing or when it expires in one year in accordance with the District of Columbia law. I authorize the use of telefax and/or photocopy of this form for the use and disclosure of protected health information as described above. I understand there may be a charge associated with the retrieval, copying and sending of records. I understand and agree to the terms of this authorization.

11. PATIENT/REPRESENTATIVE SIGNATURE:	12. DATE OF REQUEST
13. NAME OF REPRESENTATIVE:	

Office Use Only-ROI Clerk:

Date Received: Date Completed:

Date Mailed: Date Faxed: