INFORMATION RELEASE FORM

PATIENT NAME_____**BIRTH DATE**_____

I hereby give **COMPREHENSIVE REHAB** permission to **receive** and **release** all **information** to/from the following individuals / groups / agencies / organizations regarding this patient.
(Please **check** and **name / list all** that apply.)

☐ Physician(s)_____

☐ School(s)_____

☐ AEA 9_____

☐ University of Iowa Hospitals & Clinics_____

☐ Community Services_____

☐ Department of Human Services_____

☐ County Case Management_____

☐ Other_____

☐ Other_____

In the event we need to contact you, are there any restrictions?
___ **NO.** There are **NO restrictions**. Any necessary information may be given to the person answering the phone or left on the answering machine or voicemail..
___ **YES.** There **ARE restrictions**. **Please specifically list all restrictions and instructions that apply when our staff is trying to contact you.** _____

I hereby expressly grant to Comprehensive Rehab the right to make, use and/or publish information, photographs, or any other reproductions of my physical likeness for various Comprehensive Rehab communication efforts, such as pamphlets, booklets, videotapes, audiotapes, slide shows, company web site (https://comprehensiverehabinc.com), etc.

I expressly grant this right to be used for educational, marketing and/or promotional information by Comprehensive Rehab for its professional and staff communications, public relations, marketing, and public health information programs.

If the use of the information or the photographs will reveal or imply information about my medical condition(s) _____ (list conditions here), the authorization for the use of this information or photographs will expire after _____10_____ years.

Patient's name may be used in conjunction with his or her images or information in any materials. Your anonymity will be maintained by using first name, last initial and city only. _____
(Patient initials)

- I understand I may revoke this authorization by written request to Comprehensive Rehab at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I understand that once information is released pursuant to this authorization, Comprehensive Rehab can not prevent the re-disclosure of information to another third party.
- Comprehensive Rehab will not condition treatment on my signing this authorization.
- It is understood that the foregoing authorization is subject to the following LIMITATIONS:

_____ _____
(Indicate any limitations or NONE) Parent Initials

_____ _____ _____
Signature of Patient/Authorized person Authorized person's authority to sign Date

_____
Printed name of authorized person

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