PLEASE COMPLETE THIS FORM AND SUBMIT IN CLINIC, FAX TO 254-526-8604, OR SEND VIA EMAIL TO MR@INTEGRITYREHAB.NET

Integrity REHAB

NAME_____

DATE of BIRTH_____

PATIENT AT INTEGRITY btw _____ AND _____
Month/Year Month/Year

PLEASE CHECK ALL THAT APPLY:

☐ Medical Records (email) $10
☐ Billing Records (email) $10
☐ Medical Records (printed) $25
☐ Billing Records (printed) $25

☐ Release my information to another person:
- ☐ Attached is copy of Power of Attorney
- ☐ Attached is copy of Medical Consenter

Payment Method: ☐ Check ☐ Cash

TOTAL: _____

Email: _____

**** You will receive an email from WebPT within seven (7) days with a link to securely download your records****

****If sending to a Medical Provider, their email address must be provided****

☐ Medical Records (email)

RELEASE INFORMATION TO:

Individual: _____

Facility: _____

Phone: _____

Fax: _____

Email: _____

**** Provider will receive an email from WebPT within seven (7) days with a link to securely download your records****

I have been fully informed of the reasons for the request and I understand that these records and/or reports are for professional use only and will be used by staff in planning for my/my child's needs. I understand that my consent is voluntary and may be withdrawn at any time. **I understand that there may be a delay in processing my records if any information is missing or incomplete.**

_____

SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

Please allow seven (7) business days to process your record request. Please make payments out to **IR REHAB PC**. Information will be released upon receipt of payment. If you have any concerns or questions, feel free to contact our office.

Thank you,

Custodian of Medical Records
Integrity Rehab
5302 Janelle Dr, Killeen, TX 76549
(254) 699-3933
MR@integrityrehab.net
Reviewed & Updated: 071017