Release of Information Authorization

Client Name: _____
Address: _____
City: _____ State: _____ Province: _____
Country: _____ Postal Code: _____
Telephone: _____ Fax: _____ e-mail: _____
Date of Birth: _____ Social Security Number: _____

I authorize Ishman BodyCare Center & Institute to release all medical records or other Protected Health Information (PHI),including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment as requested by my health insurance carrier, Medicare or any other third-party payers.

I authorize Ishman BodyCare Center & Institute to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Ishman BodyCare Center & Institute.

I also authorize the release of my medical records or other PHI concerning my health and treatment during the period of _____ to _____ ; to be sent to the following person or company.:

Company: .....
Name: _____
City: _____ State: _____ Province: _____
Country: _____ Postal Code: _____
Telephone: Fax: Email:

I agree that these provisions will remain in effect until I provide written revocation to Ishman BodyCare Center & Institute.

_____ _____
Signature of Client or Authorized Representative Date