



Medi-Chair, LLC/Redman Power Chair  
1601 South Pantano Road # 107  
Tucson, AZ 85710  
(800) 727-6684

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**  
(Protected Health Information)

I hereby authorize \_\_\_\_\_, to release the following information from the medical record (Protected Health Information) of:

Patient Name: \_\_\_\_\_

Date Of Birth: \_\_\_\_\_ Social Security#: \_\_\_\_\_

Information To Be Released To: Medi-Chair, LLC/Redman Power Chair  
1601 South Pantano Road # 107  
Tucson, AZ 85710  
(800) 727-6684

**THE MEDICAL REPORTS REQUESTED ARE AS FOLLOWS:**

Final Diagnosis                      Progress Reports                      Physicians Orders  
History & Physical                      Consultation Rep.                      Physical Therapy / O.T. Evaluation

Describe Other: \_\_\_\_\_

**PURPOSE OF THIS DISCLOSURE IS TO PURCHASE A POWER CHAIR**

I hereby also consent to the release of the following information, which may have specific statutory protection:

Healthcare information received from another healthcare institution.

I understand that this authorization is voluntary and that I may refuse the right to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allow by law.

I understand that if the organization may no longer be protected by federal privacy regulations. I, on behalf of myself or any other person who may have an interest in the matter, hereby release the facility, it's employees, officers, and attending physician form legal responsibility or liability in regard to the acts that I have hereby authorized.

A parent or court appointed guardian must sign for a minor child.

An adult patient must sign for himself or herself unless a guardian has been appointed by a court of law (legal representatives in certain circumstances). If patient is unable to sign, he or she must make a mark (X) and have the signature of two witnesses.

I understand that this authorization will expire on \_\_\_\_\_

I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it will not have any affect on any action taken before receiving the revocation.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian Rep. / Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature Of Witness                      Date

\_\_\_\_\_  
Signature Of Witness                      Date