Community Rehab Care, Inc.
305 Centre Street
Newton, MA 02458

AUTHORIZATION TO ACQUIRE MEDICAL INFORMATION

Date: _____

Name of Client: _____ MR# _____
Address: _____
_____
_____
_____

Date of Birth: _____

I hereby authorize:

_____
_____
_____
_____
_____

To release my medical record to:

Community Rehab Care, Inc.
305 Centre Street
Newton, MA 02458
P: 617/244-8480
F: 617/244-8312

Information to be sent:
Evaluations/Progress Reports/Discharge Summary

This authorization is valid for ninety (90) days from the date of signature, during the course of treatment, and/or 90 days from discharge.

_____

Cient's Signature Date