Arm and Hand Rehab
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## Release of Medical Records

The documents accompanying this transition contain confidential health care information that is legally privileged and intended for the below named individual or entity only. The recipient of this document is prohibited from disclosing its contents and is required by law to destroy this information once authorization is complete. If you have received this transmission in error, please contact sender immediately.

I give_____ permission to release personal medical information to: Arm and Hand Rehab.

The request is for:_____ and to be faxed to (530) 626-3049.

_____
Patient's Name

_____
Patient's Signature

_____
Date