ADVANCED COGNITIVE
COMMUNICATION
REHAB CLINIC

Authorization Form

Client Name: ____
Address: ____
Address 2: ____
City: ________________________ State/Prov: __________________ Zip/Postal Code: _____________

Claim Number: ________________________________ Policy Number: _________________________
Date of Loss: ____
Date of Birth (MM/DD/YYYY): __________________________________

I, __________________________, hereby authorize, permit and allow ___________________________ of Advanced Cognitive Communication Rehab Clinic, to obtain, review, release and copy all medical and employment records pertaining to myself. I also authorize the representative of named clinic to release copies of my medical and employment records to the following list of individuals on a need to know basis pertaining to injuries sustained in the above dated accident.

1. ____

2. ____

3. ____

4. ____

Client's Signature: ______________________________ Date: (MM/DD/YYYY): ______________________

Print Name: ___________________

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