Rainbow Home Healthcare
Better Health For Independent Living

1358 7th Street East
Saint Paul, MN 55106
Business Phone: (651) 778-0562
Fax: (651) 778-9967

AUTHORIZATION TO RELEASE INFORMATION

Name: _____ DOB:_____

PMI#_____ Phone # _____ SSN# _____

_____

Address City MN Zip Code

I, _____, authorize Rainbow Home Healthcare, Inc. the release of my personal information, medical records to:

_____

Company/Provider Name (Self/Family Member)

_____

Address City MN Zip Code

_____ _____

Phone Number Fax Number

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. A photocopy/fax of this authorization will be treated in the same manner as an original. Further, I realize that Rainbow Home Healthcare, Inc. cannot prevent the redisclosure of records released as result of this request and that the records may not be subject to privacy rule protections; therefore Rainbow Home Healthcare, Inc. is released from any and all liability resulting from redisclosure.

Please fax my requested information to _____

At (Fax Number) _____.

_____ _____ _____

RP/Client Print Name RP/Client Signature Date