AUTHORIZATION TO FAX PATIENT INFORMATION

I _____ authorize Better Health Medical and Rehab to fax my
(Patient name)
medical records to the following fax number: (_____) _____.
Area code Number

I understand that medical records may contain sensitive information, and that Better Health Medical and Rehab cannot guarantee that the information will not be accidentally sent to a wrong number, received by an unintended recipient, or read by someone not authorized to read the information. Therefore I release Better Health Medical and Rehab from any liability in sending this information.

_____ _____
Patient signature Date