Mobility Warehouse
Consent for Release of Protected Health Information

PATIENT INFORMATION:

Last Name: _____ First Name: _____ MI: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: (_____) _____-_____

Alternate Telephone: (_____) _____-_____

Date of Birth: _____/_____/_____

Primary Care Physician: _____

Office Telephone: (_____) _____-_____

The above information has been given to Mobility Warehouse to provide it with information necessary to provide service to the customer listed above. Upon signature, the customer certifies that this information is correct and permits Mobility Warehouse to contact any person necessary to obtain or release any medical information pertaining to monitoring and/or improving the quality of services and health care provided by Mobility Warehouse.

Patient Signature: _____ Date: _____/_____/_____

By, If Other Than Patient: _____

Relationship: _____

Contact Information:
106 Rock Quarry Rd, Suite E
Stockbridge, GA 30281
Phone: 770-507-6008
Fax: 770-506-1152