CONSENT TO OBTAIN/DISCLOSE HEALTH INFORMATION

RE: _____

(Client Name)

I authorize the Association for the Rehabilitation of the Brain Injured (ARBI) to:

1. Obtain health information and/or medical records from hospitals, rehabilitation centers, care centers, physicians or other health care personnel and other service providers, subject to the following exclusions, if any:

   _____

2. Disclose health information and/or medical records to referring hospitals, rehabilitation centers, care centers, physicians, other health care personnel and/or service providers, subject to the following exclusions, if any:

   _____

3. Provide or use a copy/fax of this release

_____ _____

Name of Person Giving Consent Phone Number

_____ _____

Signature Date

This consent remains valid for three (3) years