AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I, _____, hereby authorize the following licensed professional (doctor, therapist, social worker, etc), who can verify my disability or health related condition, to release this information to R-Transit. This information will be used only to verify my eligibility for Paratransit services. I understand that I have the right to request a copy of this authorization, and that I may revoke it at any time.

This authorizes the following Medical Center(s) to complete **Disability Verification form**:

Medical Center: _____ Physician Fax #:_____

Physician Name: _____ Physician Phone #:_____

Address: _____
Street Address Suite City, State Zipcode

PATIENT INFORMATION

Patient Name: _____ Patient Phone #: _____

Medical Record #: _____ Date of Birth: _____

Address:_____
Street Address Suite City, State Zipcode

MEDICAL CENTER MAY DISCLOSE THIS INFORMATION TO:

Recipient Name: R-TRANSIT Phone #: 510-307-8026 Fax #: 510-307-8080

Address: 440 Civic Center Plaza, Richmond CA 94804

DURATION: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: Date:

I certify that the information on this form is true and correct. I understand all information will be kept confidential and only information required to provide the service will be disclosed to those who perform the service. I understand that it will be necessary to contact a physician familiar with my functional abilities to use public transit in order to assist in the determination of eligibility.

_____ _____ _____
Print Name Signature Date