Ruthe B. Cowl Rehabilitation Center

1. **Financial Responsibility**

I authorize reimbursement to the Ruthe B. Cowl Rehabilitation Center for all services covered by Insurance/Medicare/Medicaid. I understand and agree to be responsible for charges not covered by the above.

X______________________________ **______________________________**
Authorization Signature **Date**

2. **Medical Records**

I hereby authorize any physician or organization to release any information concerning my medical records to the Ruthe B. Cowl Rehabilitation Center.

X_________________________________
Patient/Guardian Signature

I hereby request and authorize you to provide the Ruthe B. Cowl Rehabilitation Center with any information concerning past medical history, attendance, advice, or hospitalization regarding
_______________________________________.
Patient's Name

X________________________________
Patient/Guardian Signature

3. **Pictures/Video**

I give permission for PICTURES/VIDEOS to be taken while I am receiving treatment and for these to be shown at the discretion of the Ruthe B. Cowl Rehabilitation Center.

X___________________________________ **__________________________________**
Authorization Signature **Date**

4. **Home Health Services**

Do you receive Home Health Services? **_______ Yes** **______ No**

Agency: ____

Phone: _________________________