ASPIRE MOBILITY
MEDICAL RECORDS RELEASE

I hereby authorize and request all my medical care providers/hospital facilities or other third party institutions to release to Aspire Mobility all complete clinical records documenting medical care rendered to me and/or any other records pertaining to my equipment request. This is to act as my consent to obtain and/or release medical documentation and any other pertinent health or related information as deemed necessary.

Patient or Authorized Representative **Date**

I acknowledge that I have a copy of the NOTICE OF PRIVACY PRACTICES as required by the Health Information Portability and Accountability Act. I understand that upon completion of reading the notice, any questions I may have be addressed to the Provider Privacy Officer. I acknowledge that I am in receipt of Aspire Mobility's Patient Information Handout. This document has been reviewed with me and I understand their contents.

Patient or Authorized Representative **Date**