Harbour Healthcare, Inc.

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Portsmouth, VA 23704
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www.myharbourhealthcare.com

AUTHORIZATION FOR COMMUNICATION

DATE: _____/_____/_____

Patient Name: _____

DOB: _____/_____/_____

SS# or Virginia Legal ID: _____

☐ **I'm authorizing** _____
to receive and/or send TO Harbour Healthcare

☐ **I'm authorizing** ***Harbour Healthcare to receive and/or send TO***

_____

☐ **Any and All Records From** _____ **to** _____
☐ **All diagnostic testing or types of records including images (All, X-ray, MRI, CT, NCV, etc.)**
☐ **Specifc diagnostic testing or types of records including images (All, X-ray, MRI, CT, NCV, etc.)** _____
☐ **Other** _____

For a period of:

☐ **All**
☐ **For a period** _____
☐ **Limited from** _____ **to** _____

Patient Signature: _____
(Form MUST be signed upon completion)

Harbour Healthcare Signature: _____