



Jeffrey P. Haggquist, DO, PLLC
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Authorization for Request for Release of Information

Patient Name	Date of Birth	Date
A. I, _____ hereby authorize _____ to furnish information in its possession relative to my diagnosis, treatment or account status to Jeffrey P. Haggquist, DO PLLC/The Flexibility, Sports & Rehabilitation Clinic .		
B. I understand if I refuse to sign this consent, the information will no be released. In addition, I am aware any and all consents may be revoked by me when the revocation is submitted in writing. Any such revocation shall have no effect on disclosures made prior to the date the revocation is received. The consent is valid for ninety (90) days from the date signed, except that copies of ongoing medical care records may be release to my named physician(s) unless consent is withdrawn in writing.		

Signature (Patient/Client Legal Guardian)	Date	Relationship
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Witness	Date
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The witness must be able to confirm the identity of the person in order to authorize the disclosure of information.