DRIVING FOR EXCEPTIONAL LEARNERS
Autism • Driver Rehab • ADHD • Anxiety

SAFER DRIVER SOLUTIONS
www.SaferDriver.net

Heartland MOBILITY
Driving Leads to the Roadway of Independence

Medical Release Form

This is a medical release of information authorization which allows Safer Driver Solutions to be in contact with your Medical Professional(s).

We will contact the Medical Professional in the event we require additional perspective on the proposed driver's ability to drive. This is necessary for us to best understand your driving needs.

Client Full Name _____ Client Date of Birth_____
MM/DD/YYYY

Best Contact Number _____ Email Address _____

I, the undersigned, do authorize and request the below Individual/Agency to release to Safer Driver Solutions all medical records for the above patient/client.

Medical Clinic/Agency:_____Address/City/State/Zip:_____

Medical Professional's Name: _____ Phone Number_____Email_____

Select All that Apply

- ☐ General Medical Care
- ☐ Educational/Developmental Information
- ☐ Physical Disability.
- ☐ **Cognitive Disability (not listed)**
- ☐ **Visual Impairment**
- ☐ **Spinal Cord Injury**
- ☐ Traumatic Brain Injury/Concussion
- ☐ Anxiety/ADHD
- ☐ Autism or other Executive Functioning Disorder
- ☐ **Hearing loss or Hearing Impairment**
- ☐ **Memory Loss**
- ☐ **Degenerative Neurological Conditions**

The information being disclosed may be used only for the following purposes. **Select all that apply:**

- ☐ Drivers Education Planning/Communication and Safety Concerns
- ☐ Medical Decision Regarding Driving
- ☐ Recommendation on Adaptive Equipment

I acknowledge that I have carefully read this authorization in its entirety as completed, understand its contents, and have signed this authorization as my own free act. A photocopy or exact reproduction of this authorization shall have the same effect as the original.

If this authorization is executed by a person other than the client, that person represents and declares that he/she is the legal representative of the client and has the authority to execute this authorization on behalf of him/her.

Consent to Use & Disclose Health Information:
I acknowledge that information to be released may include material that is protected by either state and/or federal law applicable to mental health information.
My signature authorizes release of all information as specified above.

Print Name:_____ Signature _____

Relationship to Client:

_____ Today's Date: _____
(Self or Parent/Guardian Month/Date/Year

NOTICE:
Medical Records Dept – please fax records to (877) 908-0320 or email to support@saferdriver.net and office@saferdriver.net.