RELEASE OF MEDICAL RECORDS

Patient Name: ____

Last **First** **MI** **Maiden (Alias)**

Date of Birth:____________________ **SS#:** ______________________

MO/DAY/YEAR

Address:____

City:___________________________ **State:**_____________ **Zip:**_____________

Day Phone: ______________________ **Evening Phone:**____________________

I hereby authorize Peak Physical Therapy to release information from my medical record as indicated below to:

Name: ____

Address:____

City:___________________________ **State:**_____________ **Zip:**_____________

Phone:_________________________ **Fax:**_____________________

Information to be released:	Dates:
☐ Initial Evaluation/Discharge Note	______________
☐ Progress notes	______________
☐ Daily Notes	______________
☐ Prescriptions	______________
☐ Other:_________	______________

I specifically authorize the release of information

- Substance abuse (including drug/alcohol abuse)
- Mental health (including psychotherapy notes)
- HIV related information (AIDS related testing)

X____ ____________________

Signature of Patient or Legal Guardian **Date**

RELEASE OF MEDICAL RECORDS

Purpose of Disclosure:

- ☐ Changing physicians
- ☐ Legal
- ☐ Consultation/Second Opinion
- ☐ School
- ☐ Continuing Care
- ☐ Insurance
- ☐ Workers' Compensation
- ☐ Other (please specify)

FOR OFFICE USE ONLY

DATE REQUEST FILLED:____________

FILLED BY:______________________

FEE COLLECTED: $______

ID
PRESENTED:___________________

____

1. I understand that this authorization will expire on _________________ (Print Date) after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release information by Peak Physical Therapy for the purpose of:
5. I understand that there is a fee of $_________ for copying and distributing my medical records.
   a. *By authorizing this release of information, my healthcare and payment for my healthcare will not be affected if I do not sign this form.*
   b. *I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.*
   c. *I have been informed that _______________________ (Name of Provider)___ will/___will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.*

____

___________________________________	______	OR	________________________	______
SIGNATURE OF PATIENT	DATE		PARENT/LEGAL GUARDIAN/ AUTHORIZED PERSON	DATE

RECORDS RECEIVED BY: ___________________ RELATIONSHIP TO PATIENT:___________________