AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Name: ____ Today's Date: __________

Address: ____ Phone: ____________ DOB: __________

RELEASE OF RECORDS

☐ I hereby authorize Leverage Physical Therapy to release my medical records and/or copies of such.

Date(s) of records to be released: From _______________ To___________________

I do NOT want following part of to be included in the released health records:

☐ Alcohol/Drug Abuse ☐ HIV Test Results ☐ Mental Health/ Development Disabilities ☐ Other _____________

Release the health records to:

☐ Myself

☐ Other: ____
(Name, Title or Facility to receive my Health Information)

____ _______________ _______________
(Address: Street, City, State, ZIP Code) (Phone) (Fax)

Delivery Option: ☐ Pick up ☐ Mail ☐ Fax

If pick up, I hereby authorize ____ to pick my records (Photo ID Required)
(Full Name of the person)

OBTAIN RECORDS

☐ I hereby authorize Leverage Physical Therapy to obtain my medical records and/or copies of such from:

____
(Name, Title or Facility to receive my Health Information)

____ _______________ _______________
(Address: Street, City, State, ZIP Code) (Phone) (Fax)

Date(s) of records to be obtained: From _______________ To___________________

- I may refuse to sign this form and it will not affect my treatment or payment for healthcare.
- I may revoke this authorization at any time before the request information is released by providing written notice
- If receiving party is not subject to medical records privacy laws, the information may be disclosed by the recipient and may no longer be protected by federal or state laws. Leverage Physical Therapy is shall not be held responsible for consequences of any such re-disclosure.
- Leverage Physical Therapy may charge administrative fees to cover cost of labor, copying and package. The Leverage Physical Therapy will inform me of any charges and arrange for payment.
- The Authorization expires on ___/____/_________ (if date is not complete here, one year after signed)

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE	RELATIONSHIP TO PATIENT	DATE