



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:

Date of Birth:

Social Security Number:

Patient Address:

Phone Number:

I hereby authorize _____ to release health information to:

Facility Name

Address

City

State

Zip

Phone Number

Fax Number (if applicable)

Purpose of Disclosure: ☐ Medical ☐ Other: _____

Treatment Date: _____

Health Information to be Released:

- ☐ Entire Medical Record
- ☐ History and Physical
- ☐ Operative Report
- ☐ Discharge Summary
- ☐ Consultation Report
- ☐ Emergency Room Record
- ☐ Physician Progress Note
- ☐ Medication Record

- ☐ Lab Report
- ☐ Radiology Report
- ☐ Cardiology Report
- ☐ Respiratory Report
- ☐ Pathology Report

☐ Other: _____

I understand that some of my health information may include information relating to Human Immunodeficiency Virus (HIV) or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug and/or alcohol abuse; or mental/behavioral health/psychiatric care. I hereby give my consent to release this sensitive information:

- ☐ YES to all
- ☐ NO to all
- ☐ Yes, HIV/AIDS only
- ☐ Yes, Substance/Alcohol only
- ☐ Yes, Mental/Behavioral/Psychiatric only

I understand that this authorization will be valid for 180 days unless otherwise specified:

☐ Other Specified Expiration Date (if applicable): _____

I, the undersigned, have read the above and authorize the staff of Affiliates in Physical Therapy, Inc. to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon. I understand that Affiliates in Physical Therapy may not condition treatment on my completion of this authorization form. I also understand that when this information is used and disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby hold harmless the above named facility from all liability and damages resulting from the lawful release of my Protected Health Information.

Signature of Patient/Parent/Guardian

Relationship

Date

Printed Name

Time