Authorization for Release of Information

PATIENT NAME: _____
Last First Middle
DATE OF BIRTH:_____/_____/_____ SSN:_____-____-_____
ADDRESS: _____
CITY_:_____STATE:_____ ZIP:_____
DAY PHONE: (____)_____EVENING PHONE:(___)_____

I hereby authorize Gambrill's Physical Therapy, LLC to release information from my medical record as indicated below to:

NAME:_____
ADDRESS:_____
CITY:_____STATE:_____ZIP:_____

Information to be released:

	Dates
☐ Initial Evaluation	_____
☐ Progress Note	_____
☐ Billing Records	_____
☐ Other	_____

Purpose of Disclosure:

☐Legal ☐Physicians ☐Consultation ☐Continuing Care ☐School
☐Insurance ☐Workers Compensation ☐Other_____

1. I understand that this authorization will expire on_____(Date)
2. I understand that I may revoke this authorization at any time by notifying Gambrill's Physical Therapy, LLC in writing and it will be effective on the date notified except to the extent action has already been taken reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the receipt and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested this information by Gambrills's Physical Therapy for the purpose of: _____
_____.

a. My health care and payment for my health care 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 will get a copy of this form after I sign it.
c. I have been informed that Gambrill's Physical Therapy will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

_____
Patient Signature Date

_____
Records Received By Date