## **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:* 

ADDRESS:						
Information to be released:         Dates         Initial Evaluation         Progress Note         Billing Records         Other         Purpose of Disclosure:         Legal       Physicians         Insurance       Workers Compensation         Other					7ID·	
Dates         Initial Evaluation         Progress Note         Billing Records         Other         Purpose of Disclosure:         Legal       Physicians         Insurance       Workers Compensation         Other       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 beer 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 Gambrill's Physical Therapy for the purpose of:	CII I		517	\1L <sup>.</sup>	2	
<ul> <li>Initial Evaluation</li></ul>	Information to	be released:				
Legal       Physicians       Consultation       Continuing Care       School         Insurance       Workers Compensation       Other	<ul> <li>Progress No</li> <li>Billing Reco</li> </ul>	ote	<u>Dates</u>			
<ul> <li>Insurance Workers Compensation Other (Date)</li> <li>I understand that this authorization will expire on (Date)</li> <li>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 beer taken reliance upon it.</li> <li>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.</li> <li>I understand that if I am being requested this information by Gambrills's Physical Therapy for the purpose of:</li></ul>	Purpose of Dis	sclosure:				
<ul> <li>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.</li> <li>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.</li> <li>4. I understand that if I am being requested this information by Gambrills's Physical Therapy for the purpose of:</li></ul>	e	•			•	
<ul> <li>b. I understand I may see and copy the information described on this form if I ask for it, and that w get a copy of this form after I sign it.</li> <li>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.</li> </ul>	<ol> <li>I understand th LLC in writing taken reliance</li> <li>I understand th redisclosure by</li> <li>I understand th</li> </ol>	at I may revoke t g and it will be eff upon it. at information us the receipt and n at if I am being re	his authorization at any fective on the date notif ed or disclosed pursuan to longer be protected be equested this information	time by notif fied except to nt to this authory Federal privon by Gambri	Tying Gambrill's the extent action prization may be vacy regulations lls's Physical	has already been subject to s.
Patient Signature Date	<ul><li>b. I understaget a cop</li><li>c. I have be</li></ul>	and I may see and y of this form after en informed that	l copy the information er I sign it. Gambrill's Physical Th	described on t herapy will no	his form if I ask t receive financi	for it, and that wil al or in-kind
	Patient Signature			Date		

Records Received By