AUTHORIZATION FOR RELEASE OF MEDICAL OR FINANCIAL INFORMATION

Patient Name:___________________________________ Birth Date:____/____/______

Street Address:___________________________________ City:__________________ State:_______ Zip:___________

I authorize release of the following information (please check at least one of the following):

____ All Physical Therapy records

____ Treatment of (please identify condition):____

____ Treatment received on the following dates: from: ____/____/______to: ____/____/______

____Other(please describe)____

I hereby authorize Lacey Physical Therapy Center, Inc to release the above information to:

Name:____ Relationship:_________________________________

Phone: _______________________________________ Email: _______________________________________

Street Address:___________________________________ City:__________________ State:_______ Zip:___________

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective when Lacey Physical Therapy Center, Inc. has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of my obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, write a letter to Lacey Physical Therapy Center, Inc.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in an inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health care information to the above named person or organization.

Signature: ____ Date:____/____/______

This authorization is valid for one year from date unless specified Date:____/____/______