PIVOT PHYSICAL THERAPY

Authorization to Release PHI (Protected Health Information) Access, Inspect, and/or Copy

Patient's Name:_____Date of Birth:_____

SSN:_____Previous Name: _____

Practice Name: _____

I request and authorize the above listed practice to release health care information of the patient named above to (***Copying Charges May Apply***):

Name: _____

Address: _____

City, State:_____Zip Code: _____

Method of Delivery

_____ I would like my records mailed via USPS

_____ I would like my records emailed to: _____

This request and authorization applies to health care information relating to the following treatment, condition, or date of treatment:

_____

_____

Or_____all health care information

Or_____Other: _____

Once my practitioner gives out the information that I want released, I know that my practitioner has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date Signed

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.