ATHLETICO PHYSICAL THERAPY | PIVOT HEALTH SOLUTIONS

Mail Request To:
Pivot Medical Records • 350 New Fidelity Court, Garner, NC 27527
Email: ROI@providerflow.com • Phone 888-653-0454 •Fax 410-324-3288

MEDICAL RECORDS RELEASE OF INFORMATION AUTHORIZATION FORM

Patient Name:_____ **Date of Birth:**_____
Address: _____ **Phone:**_____
_____ **Email:**_____

****There may be a charge for release of medical records****

Deliver To: _____ **(Individual, including Suffix or Organization)**
Address
(required to process): _____
_____

Check method of delivery:

□ **Mailing Address:**_____

□ **Email Address:** _____ □ **Fax #**:_____

Records to be Released: ***(Check All That Apply)***

□ All Medical Records □ Itemized Billing Statements □ Other:_____

Provide a copy of my medical records for all dates of service or: From:_____**To:**_____

Note: Release of records will include sensitive information such as mental health, alcohol/substance abuse and HIV/AIDS.

This authorization will be used for: ***(Check One)***

□ Patient Request □ Insurance □ Social Security/Disability □ Other:_____
□ Continuation of Care □ Attorney □ Worker's Compensation _____

- I understand communication by email has a number of risks, and there is potential that email sent or received can be intercepted, altered, forwarded and/or read by others.
- I understand that I may revoke this authorization in writing to ***350 New Fidelity Court, Garner, NC 27527*** at any time and will be effective on the date notified except to the extent that action has been taken in reliance upon this authorization.
- I understand that my health care will not be affected if I do not sign this form.
- I understand unless otherwise revoked, this authorization will expire on the following date or event:_____.
- If no date is indicated, authorization will expire one (1) year from the date signed.
- I understand that I have the right to review my health information before release. I also understand that I have a right to receive a copy of this authorization.

_____ _____
Patient Signature or Legally Authorized Representative Date

_____ _____
Printed Name of Patient Or Legally Authorized Representative Relationship of Legally Authorized Representative To Patient

****Letter of legal representation would be needed if authorization is signed by a patient's attorney*

RE-DISCLOSURE: *Notice is hereby given to the patient or legal representative signing this Authorization that Athletico cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that laws prohibit the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.*