FOLEY PHYSICAL THERAPY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

To: _____

_____

_____

I hereby authorize the above-named health care provider to furnish, discuss and release all information and records requested below in writing covering findings, treatment rendered, and opinions as to my condition as authorized below.

Records authorized for release: Diagnostic Tests ☐ X-rays ☐ MRI ☐ EMG/NCV Testing ☐ CT Scan

- ☐ Examination/Evaluation Records
- ☐ Operative Report
- ☐ Other _____

Release records to: Foley Physical Therapy via:

FoleyPhysicalTherapy@gmail.com or FAX: 412.345.8140

I UNDERSTAND:

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.
- I may refuse to authorize disclosure of health care information, and if I refuse or if I revoke the Authorization, I understand that such refusal or revocation may result in improper diagnosis or treatment or other adverse consequences.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may not be subject to federal or state law protecting its confidentiality.
- I may revoke this authorization at any time by executing a written revocation, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to inspect or copy information disclosed hereunder.
- I understand that treatment will not be denied if I refuse to sign this Authorization.
- This Authorization to obtain/release records will be effective until revoked in writing by me or for 12 months from the date hereby signed, whichever comes first.
- No enrollment or eligibility for benefits, treatment or payment is intended or expected to be conditioned upon this Authorization.

X _____ _____

Patient Signature Date

X _____ _____

Parent or Guardian Signature Date