Patient's Authorization to Release Medical Records

Please provide complete and accurate information when submitting this form. ***Sitka Physical Therapy*** will only process valid and complete authorization forms.

Patient's Name: _____ Date of Birth: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone #: _____ Social Security Number: _____

……..

I authorize release of my health care information concerning *(please check off at least one of the following):*

1.___ All Physical Therapy records 2.___Treatment of *(please identify condition):*_____

3.___ Treatment received on the following dates: from: _____to: _____

4.___ Other *(please describe)*_____

.....

Release:

I authorize **Sitka Physical Therapy** to release my personal health care information **to:**

Name: _____ Care of: _____

Address: _____ City: _____ State: _____ Zip:_____

Telephone #: _____ Fax #:_____

……...

Request:

I authorize: Name: _____

Address: _____ City: _____ State: _____ Zip:_____

Telephone #:_____Fax #: _____

To release my private health information as identified above to: **Sitka Physical Therapy LLC**
700 Katlian St., Suite E
Sitka, AK 99835

Please list the purpose or need of your health information. Please check one:

1.___ Transfer of Care 2.___ Moving 3.___ Seeing referred practitioner 4.___ Other _____

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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 Sitka Physical Therapy 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 Sitka Physical Therapy Medical Records Department.

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: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representatives Name: _____

Signature: _____ Relationship: _____

…….

This authorization is valid for one year from date unless specified _____ (date)

…….

****** In most cases a first request for record copies has no charge. Sitka Physical Therapy reserves the right to charge for additional requests for the same records.

700 Katlian Street., Suite E, Alaska 99835 ◆ (907) 747 4559 (Phone), (907) 747 5415 (Fax)