AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Please read all information and instructions before completing and signing the authorization form

Patient's Name: ____ Birth date:___________
(please print) LAST FIRST MI

I authorize Opus Physical Therapy and Performance Inc. and its affiliates, employees and agents to discuss and/or release my protected health information with:

Name: _____________________________________ Affiliation: _________________

Name: _____________________________________ Affiliation: _________________

Name: _____________________________________ Affiliation: _________________

TYPE OF MEDICAL INFORMATION REQUESTED:

❏ All Records
❏ Billing Records
❏ Other________________________________
❏ My health information relating only to the following treatment or condition________
❏ My health information relating only for the following date(s)_____________________

REASON FOR REQUEST:

❏ Personal ❏ Transfer of Care ❏ Disability ❏ Insurance ❏ Legal Review
❏ Continuing Care
❏ Other (please explain):____

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. 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)
3. You have the right to revoke or cancel this authorization, in writing, at any time.

This authorization will expire in 90 days from the date of signing if not otherwise specified. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

Patient signature____ Date___________________________

Parent or Legal Guardian____________________________________ Date___________________________
Relationship to patient, if other than patient____
(You may be required to provide legal documentation as proof for power of attorney or guardianship)

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