Authorization to Release Medical Information
Juneau Physical Therapy

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Patient Information

Name ____

Mailing Address ____ City/State/Zip ____________

Date of Birth ________________ Social Security # _____________________ Phone _________

Information to be Released From (please do not fill out this section)

I hereby authorize _______________________ to release the following medical information for this patient.

Information to be Released To (please do not fill out this section)

Name of Facility/Organization/Patient ____

Address ____ City/State/Zip ____________

Phone _____________________________ Fax _______________________

Type of Information to be Released (this is to be filled out by the Therapist ONLY)

Purpose or need for information being released:

______ Further medical treatment ______ Legal proceedings

______ Insurance claim ______ Other (specify)

Dates of treatment: from ______________ to ______________

Specific information to be released:

______ Permission to discuss current diagnosis

______ Operative report Area of interest ___________________________

______ X-ray report Area of interest ___________________________

______ MRI report Area of interest ___________________________

______ Other (specify)

By signing this form below, I give my authorization for release of records as indicated above.

If the information to be released pertains to alcohol or drug abuse, I understand the confidentiality if information is protected by federal law (42CFR, Part 2). Furthermore, I understand that my records may contain information regarding the diagnosis of HIV, AIDS, other sexually transmitted diseases, drug abuse, alcohol use, mental illness or psychiatric treatment.

* Prohibition on re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by Federal Regulation (42CFR, Part 2) prohibiting you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is NOT sufficient for this purpose.

Patient Authorization to Release Medical Information

____ ___________________________

Signature of Patient or Legally Responsible Party Relationship to Patient

____

Date

This authorization to release information expires in 90 days from the date it is signed by the patient, unless revoked in writing by the patient prior to the expiration date. To be a valid authorization, it must be signed and dated after dates of service for requested information.