CC's Physical Therapy

General Medical Records Release and

Authorization for Use of Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

Phone: _____

Last four SSN: _____ **Date of Birth:** _____

I authorize _____, of CC's Physical Therapy, to disclose/release the following information:
(Name of Physician)

(check all applicable) ____ All record _____ Billing records _____ Other: _____

Please send the records listed above to:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

This authorization shall not be valid for greater than one year from the date of signature.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law. By signing below, I represent and warrant that I have the authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) *Date*

_____ _____

Printed name of patient representative *Representative's authority to sign for patient*

(i.e. parent, guardian, POA, executor)

You have the right to revoke this authorization, except to the extent of the custodian of records has to rely on it, by sending your written request to: Office Manager; CC's Physical Therapy; 207 W Front Avenue, Bismarck, ND 58504