Authorization for Release of Information

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: _____-_____-_____ SOCIAL SECURITY NUMBER: _____-_____-_____
MO DAY YR

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

DAY PHONE: ( ) _____- _____ EVENING PHONE: ( ) _____- _____ CELL PHONE: ( ) _____-_____

I hereby authorize Layne Physical Therapy, LLC to release my Physical Therapy records to:

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

- Physical Therapy progress notes

1. I understand that this authorization will expire **180 days** after I have signed the release form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used for disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST WAS FILLED: _____ BY: _____

IDENTIFICATION PRESENTED: _____ FEE COLLECTED: $ _____