A-1 Physical Therapy

Authorization for Disclosure of Health Information

1. I hereby authorize A-1 Physical Therapy to disclose the following information from the health records of:

Patient Name: _____ Date of Birth:_____

Phone Number ( )_____ SSN_____

Address_____ City_____ State_____ Zip_____

Covering the health period from: ___/___/_____ through___/___/_____

2. Information to be disclosed:

____ Complete Health Record ____ Discharge Summary

____ History and Physical Exam ____ Progress Notes

____ Consultation Reports ____ Lab Tests

____ X-ray Reports ____ Photo/Video/Digital Image

____ Other (please specify)_____

I understand that this will include information relating to (check if applicable)

____Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency (HIV) Infection

____Behavioral Health Service/Psychiatric

____Treatment of Drug Abuse

3. This information can be disclosed to the following persons: _____

_____

4. I understand this authorization can be revoked in writing at any time, except to the extent that the action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____

5. A-1 Physical Therapy, it's employees, and therapists are hereby released from any legal responsibility or liability for disclosure of it's above information to the extent indicated and authorized herein.

Signature:_____ Date: _____