

Active Physical Therapy Solutions, PC
Authorization for Release of Medical Information

Patient's name: _____	Date of Birth: _____
Address: _____	City/State/Zip: _____
SS#: _____	Patient's Phone #: _____

OR

<input type="checkbox"/> I authorize Active Physical Therapy Solutions to release information to:	<input type="checkbox"/> I authorize Active Physical Therapy Solutions to obtain information from:
_____ Name of Provider or Facility	_____ Name of Provider or Facility
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone # / Fax #	_____ Phone # / Fax #

Purpose for this request: <input type="checkbox"/> treatment <input type="checkbox"/> insurance <input type="checkbox"/> other: _____
Information to be released/obtained: _____
This authorization is valid for: (choose one of the following)
<input type="checkbox"/> This request only.
<input type="checkbox"/> This authorization will end on the following date: _____

I understand that:	
<ul style="list-style-type: none">• I may revoke this authorization at any time by submitting a written request to Active Physical Therapy Solutions, PC at the address below, except where a disclosure has already been made in reliance upon this authorization.• Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. Once this information is disclosed to the party you requested, Active Physical Therapy Solutions, PC cannot be responsible for that party's handling of your health information.• If my records contain information regarding diagnosis or treatment of sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment, I give permission to include this in my request.	
_____ Signature of Patient/Legal Guardian	_____ Date