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

☐ I authorize Active Physical Therapy Solutions **to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone # / Fax #

☐ I authorize Active Physical Therapy Solutions **to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone # / Fax #

Purpose for this request: ☐ treatment ☐ insurance ☐ other: _____

Information to be released/obtained: _____

This authorization is valid for: (choose one of the following)

☐ This request only.

☐ This authorization will end on the following date: _____

I understand that:

- 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

91 Columbus Street , Auburn, NY 13021
Phone: (315) 515-3117 Fax: (315)515-3121