HANSEN
PHYSICAL THERAPY

- Personal
- Professional
- Experienced Physical Therapy

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name____Birth date_______________
Are medical records filed under another name? ____________________ Phone number____________

INFORMATION TO BE RELEASED **BY**	INFORMATION TO BE RELEASED **TO**
REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER	**REQUEST MUST HAVE COMPLETE ADDRESS OR FAX NUMBER**
____ Organization/Person Name	____ Organization/Person Name
____ Street Address City, State, Zip	____ Street Address City, State, Zip
____ Phone Fax	____ Phone Fax
____ Email	____ Email

TYPE OF MEDICAL INFORMATION REQUESTED:
❏ All Records ❏ Billing Records ❏ Other______________________________
❏ My health information relating only to the following treatment or condition____________________
❏ My health information relating only for the following date(s) _____________________

REASON FOR REQUEST: ❏ Personal ❏ Transfer of Care ❏ Disability ❏ Insurance ❏ Legal Review
❏ Continuing Care ❏ other (please explain):____

1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.
2. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits).
3. You have the right to revoke or cancel this authorization, in writing, at any time.

<u>THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORDS UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY.</u>

This authorization for record release will expire one year from the below date.

My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization.

Patient signature____ Date__________________________
Parent or Legal Guardian_________________________________ Date__________________________
Relationship to patient, if other than patient____