

Patient Name: _____ D.O.B.: _____ Phone #: _____
(Please Print)

Address: _____
Street or P.O. Box City State Zip Code

Therapy Solutions is hereby authorized to obtain, exchange, and/or disclose information regarding my health care and treatment.

Release Information From:

Provider/Facility Name:
Address:
City/State/Zip:
Phone:

Release Information To:

Provider/Facility Name:
Address:
City/State/Zip:
Phone:

Date(s) of treatment to be released: _____

Records release method: Mail Pick-Up Patient Portal Fax: _____

Communication method: Phone Email: _____

Information to be released: Initial Examination Re-Evaluation Other: _____
 Daily Notes Discharge

Information to be obtained: MRI CT Scan Other: _____
 X-Ray Operative Report

Reason for disclosure of information: Diagnosis and Treatment Insurance Processing Legal Process
 Benefit Management Billing/Payment Disability Claim
 Other: _____

I understand that this authorization is voluntary. Therapy Solutions will not condition treatment on your signing this authorization, unless treatment is research related or Therapy Solutions is providing you with healthcare for the sole purpose of a third party report, such as an employer or school. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations. I understand that I may revoke this authorization at any time by notifying Therapy Solutions in writing, but if I do, it will not have any effect on any actions that Therapy Solutions took before it received the revocation.

This authorization will expire one year from the date of signing unless I indicate an event or earlier date here: _____

Signature (Parent or legal guardian if a minor or an adult unable to sign)

Relationship to Patient

Date