

AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS



Patient name: _____

Patient address: _____

Patient Birth Date: _____ Patient Phone #: _____

Subject to the conditions set forth below, I do hereby authorize **First Choice Physical Therapy, Inc.** to release the following Medical records: _____

To the person and/or institution listed below:

Person/Institution Name: _____

Address (w/City, State, and Zip): _____

The recipient shall not make further disclosure of the medical records without permission of the patient or patient's legal guardian.

This information is to be used for: Social Services or State Agencies Transfer of Care
 Disability Claim Second Opinion Continuing Care Referral
 Attorney or Legal Matter Insurance Company
 Other _____

The information may be communicated: Orally or Written or Both

This release of information consent form remains in effect until (date) _____ or until the patient or legal guardian shall revoke this authorization.

I understand that my records are protected under North Dakota state and federal laws and regulations and cannot be disclosed without written consent unless otherwise provided for by regulation. I have reviewed the above information and understand fully its contents. The policy for release of medical information is: a) no charge for medical records released to physician(s) or other health care providers, b) a fee schedule is applicable for medical records released directly to patient(s) or other non-medical related parties. **PREPAYMENT IS NECESSARY WHEN RELEASING MEDICAL RECORDS.**

Signature _____ Date: _____

If NOT the patient, relationship of signee to the patient: _____

Witness _____ Date: _____