# AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL RECORDS

First Choice Physical Therapy, Inc.

Patient name: _____

Patient address: _____

Patient Birth Date: _____ Patient Phone #: _____

Subject to the conditions set forth below, I do hereby authorize _____

To release the following Medical records: _____

To **First Choice Physical Therapy, Inc.**

**Please fax to:** 701-838-9603 **OR** **Mail to:** 2111 Landmark Circle, Ste B
Minot, ND 58703

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: _____