HEALTH RECORD RELEASE AUTHORIZATION FORM

Client Name:____ Date of Birth:____________________ BRN (*Staff to Complete*):____________________

Phone:(________)________-___________ Address:____

I would like to receive/have this record released via ☐ FAX ☐ Paper ☐ Email Email Address:_________________________

Disclose Health Record TO:

Facility:____

Name:____

Address:____

Phone:(________)__________-______________ FAX:(__________)__________-______________

I AM REQUESTING HEALTH RECORD FOR DATES: From:________________ To:_________________ ☐ ALL

Information To Be Released:

(*please specify. **Your initial is required for each record release***)

☐ Assessment Sheet________ your initial

☐ Goal Attainment________ your initial

☐ Progress Notes________ your initial

☐ Exercise Sheet__________ your initial

☐ Discharge Report________ your initial

☐ Consent to Service, and to Collect, Use and Release Personal Health Information________ your initial

☐ Other:____ (your initial)

Please specify the purpose of disclosure:

____

____

Expiration date or event (if leave blank, this Authorization expires 90 days from the date signed):___________________________________

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying Mobile Physio in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure.
4. I may refuse to sign this authorization and that it is strictly voluntary.
5. If I do not sign this form, my health care by Mobile Physio will not be affected.

Client/Authorized Representative Signature: ___________________________________ Date: ______________________________

Client/Authorized Representative Printed Name:___________________________________ Relationship to the Client: ______________________________