Authorization to Release Healthcare Information

Patient Name: _____ **Date of Birth:** _____ **SSN:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____

Please Note: Copy Fee May Be Charged for Medical Records

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: Grace Physical Therapy **Phone:** (843) 871-3522 **Fax:** (843) 871-3523

Address: 440 Old Trolley Rd. Suite D. Summerville, SC 29483

☐ Please Mail Records. ☐ Please Fax records.

This information may be disclosed to and used by the following individual or organization:

Facility Name: _____

Facility Address: _____

Phone number: _____ **Fax Number:** _____

Types and Dates of information to disclose:

Specific Information Requested: _____

_____

Dates: _____

The purpose of disclosure is: ☐ Change of Insurance or Physician ☐ Continuation of Care

☐ Referral ☐ Other: _____

RESTRICTIONS: Only Medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Grace Physical Therapy. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date: _____

If I fail to specify an expiration date, this authorization will expire six months from the date of signing.

I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

X _____ X _____

Signature of Patient/Parent/Guardian **Date**

X _____ X _____

Signature of Authorized Representative **Date**