Authorization to Release Healthcare Information

Name: ____ Date of Birth: ______/______/_______
First MI Last

Previous/Other Name: ____
First MI Last

I request and authorize MVPT Physical Therapy ("MVPT") to use, disclose, or release my protected information (medical records) specified below:

Name of Person or Company: ____

Address: ____
Street City State Zip Code

INFORMATION REQUESTED: (Check applicable box(es), giving the dates of approximates dates covered by each)

O Complete Medical Record

O Physical Therapy Initial Evaluation & Progress Reports ONLY

O Complete Medical Record & Financials

O Daily Treatment Notes ONLY

O Financials ONLY

O Other ______________________________________

Dates of care requested:_____________ to: _______________

PURPOSE for which the information is being released (check one)

O Personal O Legal O Insurance O Consultation with Specialist

O Permanent transfer to another provider O Other__________________________________.

I UNDERSTAND THAT:

• The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws.

• MVPT Physical Therapy will treat me even if I decline to sign this authorization.

• Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.

• I can revoke this authorization at any time by submitted in writing to: MVPT Physical Therapy 40 South River Road Unit 58 Bedford, NH 03110. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires six months from the date or signature, or on: _____ / ____ / _____

I have been offered a copy of this form.

Signature: ____ Date: __________________
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Relationship to Patient: (If patient is under age of 18): O Mother O Father O Legal Guardian