

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

**Authorization is not required for the use or disclosure of information related to treatment, payment, or healthcare operations, or if permitted by law or rules.**

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone: (Home) \_\_\_\_/\_\_\_\_/\_\_\_\_ (Work) \_\_\_\_/\_\_\_\_/\_\_\_\_ (Cell) \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_ I hereby authorize Pitman Creek Physical Therapy to release all records regarding my care to the individuals identified below:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Pitman Creek Physical Therapy may release this information as long as it retains my files: \_\_\_\_\_ Yes \_\_\_\_\_ No

If no, please specify expiration date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand that this authorization does not expire unless I have indicated an expiration date above

This authorization may be revoked or terminated by submitting a written revocation to Pitman Creek Physical Therapy

Information disclosed pursuant to this authorization is subject to re-disclosure by the recipient, and may no longer be protected.

If you refuse to sign this authorization, you may not be denied appropriate treatment by this facility.

Signature of Patient: \_\_\_\_\_

Signature of parent or authorized representative \_\_\_\_\_  
Relationship \_\_\_\_\_

Date: \_\_\_\_\_