



Patient's Authorization to Release Medical Information

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1996, (HIPAA), in order for your healthcare provider or staff of ProFysio Physical Therapy to discuss your medical condition or billing information with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

In accordance with the above, I \_\_\_\_\_,

Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_,

hereby authorize ProFysio Physical Therapy to discuss with and release my medical and/or billing information, scheduling changes to the following individuals:

- Myself only
Family Members (specify name)
Other (specify name)

Furthermore, I understand that if there is any information in my medical record I do not want discussed with or released to the above, I must designate it here by stating what information is to be excluded:

I can be contacted at:

- Home Phone: Mobile Phone:
Work Phone: Other:

Voicemail/Answering Machines:

- YES, you may leave messages regarding scheduling, billing, and physical therapy/health information.
NO, I do not want messages left on my voicemail or answering machine.

Patients Name (Please Print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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