A C I C Physical Therapy

Medical Information Release Form

HIPAA Release Form

Name: _____Date of Birth: _____/_____/_____

We are unable to discuss your treatment/account information with anyone unless you give us written permission.

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and any claims/statement information. This information may be released to:

[ ] Spouse Name: _____
[ ] Child(ren) Name(s): _____
[ ] Parent Name: _____
[ ] Other Name: _____
[ ] Information is not to be released to anyone.

This release of information will remain in effect until terminated by me in writing.
Messages

Please reach me by [ ] home [ ] work [ ] cell [ ] email [ ] all

Number _____

Email:_____

If unable to reach me:
[ ] You may leave a detailed message/email/text
[ ] Please leave a message/email/text asking me to contact you
[ ] Other
_____

The best time to reach me is (day) _____ between (time) _____.

I have received a copy of this office's Notice of Privacy Practices.

Signed: _____Date: _____/_____/_____