Merrimack Valley PHYSICAL THERAPY

Authorization to Release Healthcare Information

Name: _____ Date of Birth: _____/_____/_____
First MI Last

Previous/Other Name: _____
First MI Last

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

Name of Person or Company: _____

Address: _____
Street Address City State Zip Code

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

O Complete Medical Record
O Complete Medical Record & Financials
O Financials ONLY
O Physical Therapy Initial Evaluation & Progress Reports ONLY
O Daily Treatment Notes 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.
- Merrimack Valley 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: Merrimack Valley 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