PARACLETE PHYSICAL THERAPY

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL MEDICAL INFORMATION

I, _____ DOB _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

BEST CONTACT NUMBER: _____

You're requesting PARACLETE PHYSICAL THERAPY to:
RELEASE or OBTAIN MEDICAL RECORDS: (Please Select the Correct Request Below)

RELEASE PARACLETE PT RECORDS: **(_____)** Authorize Paraclete Physical Therapy, 195 Falcon Drive, Fredericksburg, VA 22408 to **RELEASE** the information to (Name of Organization specified below), in accordance with the laws of the Commonwealth of Virginia and Paraclete Physical Therapy policies.

OBTAIN MEDICAL RECORDS: Return Fax #: (540) 735-0262 (____) Authorize Paraclete Physical Therapy to **OBTAIN** medical information from (Name of Organization specified below):

NAME/ORGANIZATION _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

PHONE _____ FAX _____

INFORMATION TO BE RELEASED/OBTAINED: Dates of Service: _____ To _____

Therapy notes □	Radiology reports □	Hospital records □	Lab reports □
Emergency room reports □	History and physical □	HIV records □	Consultation □
Drug and alcohol *□	Psychiatric notes *□	Complete chart *□	

Other (please specify) _____

** Complete chart request do not include psychiatric, drug and alcohol or HIV records unless specifically requested on this form.*

The purpose for this disclosure of the above information is: □ Continuing Care □ Personal Use

□ Other _____

The HITECH Act allows for copy charges consisting of $6.50 a chart for the patient and their attorney. There is a fee of $5 for a CD of your X-Rays. Any requests from anyone else will be charged the VA allowed Copying Fee, $10 Admin Fee, .50 for each page up to 50 pages and .25 for all pages after that.

I hereby authorize, allow and cause the release the information indicated above. No threat of utter coercive measures has induced me to sign this form and I do release Paraclete Physical Therapy from and covenant not to sue Paraclete Physical Therapy for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment, payment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire in 1 year after the date specified below, or on the date, event or condition described as: _____

Patient/Guardian Signature: _____ Date _____

Relationship to Patient: _____

Witness Signature: _____ Date _____