FOREVER FIT
PHYSICAL THERAPY & WELLNESS

Medical Records Release Form

Authorization to Disclose Protected Health Information

I, _____ _____
(patient name) (date of birth)

hereby authorize the use or disclosure of my personal medical records and/or identifiable health information** to the parties identified below.

I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

There will be a fee for the requested medical records.
Please allow a minimum of 1-2 weeks processing time.

Individual Party or Organization Name	**Mailing Address**	**Phone/Fax #**

SIGNATURE: _____ **DATE:** _____

We strongly recommend medical records be sent to parents. If we should have to reprint your child(ren)'s records at a later date, there may be an additional fee.

PATIENTS 18 YEARS OF AGE ARE CONSIDERED ADULTS AND THEREFORE MUST REQUEST THEIR OWN MEDICAL RECORDS

Parent Name	
Relationship	
Mailing Address	
Phone Number	

Medical record release is effective until completion of plan of care
**Identifiable health information as defined by HIPAA includes name, date of birth, diagnoses, etc