AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ hereby authorize Progress Rehabilitation Network, LLC
(Name of Patient or Personal Representative) dba InMotion Physical Therapy to release the information listed below to:_____

_____

_____

_____
(Fill in above lines with name & address of person to receive information)

(_____) ____-_____ (_____) ____-_____
(Phone Number of recipient) (Fax number of recipient – *optional*)

from the designated record set of _____whose
(Patient's Name)
birth date is_____, whose social security number is _____-____-_____, and whose address is: _____

_____

_____

The following information shall be released (mark all applicable):

❒ Entire Medical Record, Except for Records Concerning Mental Health Treatment Alcohol, or Other Drug Treatment, HIV/AIDS Information, and Genetic Information.
❒ Mental Health Treatment Records
❒ Alcohol or Other Drug Treatment Records
❒ HIV/AIDS Records
❒ Genetic Information
❒ Laboratory Reports
❒ X-Ray or Other Photographic Reports
❒ Immunization Records
❒ Other:_____.

The purpose of the authorization is:

❒ At the Request of the Individual or Personal Representative

❒ Other:_____.

The information should be released for the following time period:

from _____ to _____
(Start Date) (End Date)

3001 Hungary Spring Road Ste D • Richmond, VA 23228
Phone (804) 756-8490 • Fax (804) 756-8494

I understand that I have the right to revoke this authorization by giving written notice to the health department. I understand that if the health department has already used or released my health information in reliance on this authorization, that I cannot revoke the authorization. If I refuse to sign this authorization, the above-described health information will not be disclosed except as provide by law.

I understand that the health department may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization unless am to receive health care solely for the purpose of creating protected health information to be disclosed to a third party or as otherwise authorized by law.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that this authorization is valid until the date of expiration listed below, or until I revoke it in writing by delivering a written revocation to the health department.

I have a right to inspect and copy the information contained in my designated record set. I am entitled to a copy of this authorization if the health department is seeking this authorization.

This authorization for release of protected health information terminates on _____.
(Date)

Signature:_____ Date:_____

If you are the personal representative of the patient, please specify your relationship to the patient:

Relationship:_____

Printed Name:_____

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