restore physical therapy
541-908-7959 ptrestore@gmail.com 966 NW Circle Blvd. Corvallis, Or 97330

RELEASE OF MEDICAL RECORDS FORM

Patient Name: _____ Date of Birth:_____

I authorize Restore Physical Therapy, LLC and Kerry Boysen, PT to disclose my protected health information only in the specific manner, for the named reason, and to the specific individual(s) described below.

Specific description of information to be used or disclosed:

_____

_____

Reason for requested use or disclosure:

☐ Patient request (personal reasons)
☐ Employment related or to substantiate a disability claim
☐ Other : _____

Person(s)/Physician or Entity(ies) to whom this practice will give my information:

Name: _____

Address: _____

Phone: _____

Fax: _____

Email: _____

This authorization will expire on the following:

☐ Date: _____

☐ Event (relating to patient or the purpose of the disclosure): _____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed authorization form.

Signature: _____ Date: _____

Relationship to patient: _____ Date: _____
(If signed by a personal representative of patient)