A Joint Effort Physical Therapy

1045 E Klatt Road Anchorage, AK 99515

Release of Information

Patient Name____ DOB______________________

I hereby authorize A Joint Effort Physical Therapy to **send / receive** my medical records as follows.

****Please Initial and Specify Dates of Service****

____ Chart Notes for Dates of Service ____________________________________

____ Imaging Reports ____________________________________

____ Operative or Procedure Reports ____________________________________

____ Complete Medical Records for all services ____________________________________

____ Other ____________________________________

From/To ____________________________________

Address ____________________________________

Phone # ______________________ Fax # ______________________

By Signing this form, I am agreeing that I understand the following:

My health records are protected under HIPAA/PHI regulations.

I may revoke this authorization at any time by notifying A Joint Effort Physical Therapy in writing, except that revocation will not cancel any action taken by A Joint Effort upon the original Authorization for Release of PHI.

This Authorization of Release will expire in 1 year from the date signed.

There may be a fee for copying these records and prepayment is required.

Patient Signature ____________________________________ Date ______________________

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Notice to Receiving Entities: Protected Health Information Disclosure Statement

The Information on the above patient has been disclosed to you from records protected by A Joint Effort Physical Therapy and or federal confidentiality rules 42 CFR part 2. Receiving entities are prohibited from further disclosure without the written consent of the above patient. A general authorization for release is not sufficient for this purpose.