WILDSTRIDE
PHYSICAL THERAPY LLC
UNLOCK MOVEMENT. UNLEASH POSSIBILITY.

Authorization for Release of Information

This form authorizes WildStride Physical Therapy, LLC and Dr. Emily Jones, PT, DPT, CMT to release or obtain your health information as described below. Completion of this form is voluntary. Please read it carefully and complete all required fields.

Patient Information

Full Name: _____

Date of Birth: _____ Phone Number: _____

Information To Be Released To/Obtained From

Name/Facility: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Type of Information to Be Released

☐ Evaluation Summary

☐ Treatment Notes

☐ Progress Reports

☐ Entire Record

☐ Other: _____

Purpose of Disclosure

☐ Coordination of care

☐ Legal

☐ Insurance

☐ Personal Use

☐ Other: _____

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Expiration & Right to Revoke

This authorization will expire one year from the date of signing unless otherwise specified here: _____.

I understand I may revoke this authorization at any time by providing written notice to WildStride Physical Therapy. Revocation will not apply to information already released in reliance on this authorization.

Legal Protection & Disclaimer

I understand that:

- I am not required to sign this form to receive treatment.
- Information disclosed pursuant to this release may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- WildStride Physical Therapy LLC is not responsible for unauthorized access to information that occurs after it leaves our possession.
- I release WildStride Physical Therapy LLC and Dr. Emily Jones from any liability for the disclosure authorized herein, provided such disclosure is made in good faith.

Patient Signature: _____ Date: _____

Printed Name: _____

Parent/Guardian Signature (if applicable): _____

Parent/Guardian Printed Name: _____ Relationship: _____