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Synergistic Physical Therapy

HIPAA Information Release Authorization Form

Synergistic Physical Therapy

I hereby consent to the release and disclosure of my personal health information to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone #: ( )_____ Fax #: ( )_____

For the following purpose:

_____

_____

_____

This release authorization includes my personal health information consisting of:

_____

_____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of the above practice having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Patient Name:

_____ _____

Patient Signature Date