LoHi PHYSICAL THERAPY

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.
This release is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

TO: Catalyst Therapies, LLC
1525 Raleigh St, Suite 210
Denver, CO 80204
Telephone 303-458-9660
Fax 303-458-9661
www.LoHiPT.com

PATIENT:

Name:

Birth Date:

RELEASE TO:

(Name & address, organization, agency, individual to whom information is to be released)

I authorize the above-named health care provider to release the information specified below to the organization, agency, or individual named on this request.

Information Requested:

__ Copy of history & physical, discharge summary & operative reports.
__ Copy of outpatient & emergency room admissions
__ Copy of medical- hospital records
__ Copy/release of health care records from other providers
__ Copy/release of interpretations of x-rays, MRIs, CT Scans
__ Other (specify) _____

_____

used:

Condition(s) and Dates of Care Covered: __

All past admissions or care at this facility

__ Limited to treatment dates & for conditions described as follows: _____

_____

Purpose(s) or need for which information is to be

___ for continuity of care for this patient ___ injury or claim evaluation

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time in writing to Catalyst Therapies, LLC, at the address above, effective the date Catalyst Therapies, LLC receives the written request.

_ **Use of Copies**: A copy of this authorization with my signature thereon: ___may ___ may not; be utilized with the same effectiveness as an original.

DATE: SIGNATURE OF PATIENT or AUTHORIZED PERSON:

PERSON AUTHORIZED TO SIGN FOR PATIENT:

Print or type name:

_____

State how authorized:

_____ _____