Smith
THERAPY PARTNERS

Medical Records Release Form

Authorization for Use/Disclosure of information: I voluntarily consent to and authorize Smith Therapy Partners (STP) to use or disclose my health information during the terms of this authorization to the recipient(s) the that I have identified below.
Recipient: I authorize my healthcare information to be released to the follow recipient(s)

Name: _____

Address: _____

Purpose: I authorize the release of my health information for the following specific purpose:_____.
Note: "at the request of the patient "is sufficient if the patient is initiating this authorization)

Information to be disclosed: I authorize the release of the following health information: (check the applicable reason below)
_____All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received at STP.
____Only the following records or types of health information_____.

Term: I understand that this authorization will remain in effect:
_____ From the date of this authorization is signed until the ____ day of _____, 20__.
_____ Until the provider fulfills this request.
_____ until the follow event occurs: _____.
Redisclosure: I understand that STP cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.
Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I do not sign, it will not affect the commencement, continuation or quality of my treatment at STP. If I change my mind, I understand that I can revoke this authorization by providing written notice of revocation to the Smith Therapy Partners HQ office at the address listed below. The revocation will be effective immediately upon STP receipt of my written notice, except that the revocation will not have any effect on any action taken by STP in reliance on this authorization before it received my written notice of revocation. **Questions**: I may contact the STP @ 10785 W Twain Ave suite 223 Las Vegas NV 89135 or by telephone 725-726-7847.

_____ _____ _____.
Signature Date Signature of witness
If individual is unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Name of Guardian Legal Relationship Date Witness