HAMPTON PHYSICAL THERAPY GROUP LLC
1721 N King St, Hampton VA 23669
Tel: 757-722-0309 Fax 757-351-4101

HIPAA Release Form

I,_____, give my permission for _____ to disclose my complete health record including, but not limited to intake forms, evals, treatment notes, and billing records for all conditions, past, present, and future periods,

To following individual(s) or organization(s):
_____.

Please detail the reasons why information is being shared, _____.

I understand that the person(s)/organization(s) listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them. I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to HPTG.

Signature Signature: _____ Date: _____
Print your name: _____