Mt Ascension Physical Therapy Authorization for Disclosure of Individual Health Information

Patient Whose Information	is to be Disclosed (please print	t):	
Street Address:	- The state of the	Date of Birth:	
City:		Daytime Telephone:	
Street Address; City:	State:	ZIP Code:	_
Person(s) or Entity(ies) to V Name(s):	Whom Information May Be Dis	closed (please print): Daytime Telephone: ZIP Code:	
Street Address:		Daytime Telephone:	
City:	State:	ZIP Code:	
□ Physical Therapy Records // *Please indicate case	I by Ascension Physical Therap or dates of service (example: neck i	y (Check all that apply):	
Other:	2 0		
(Specify other informs	tion muth animal 5 1: 1		
	tion authorized for disclosure if not	listed in categories above)	
Reason for disclosure (checl	k one):	en a la l	
At the request of the author	food in dismiller 1		
	200 marvidual of entity.		
Other reason for disclosure (o			
o diet reason for discrosme (o	ther than "at the request of the author	rized individual or entity") (describe):	
Length of Time for Which T	his Authorization is Valid:		
Length of Time for Which T This authorization is valid up to 2 tas occurred, as stated in the authorization will have to be rene 24 months from the date of sign Until (Month/Day/Year) Until all information relating to or "formal research") (S	his Authorization is Valid: 24 months (or a shorter period of time torization. If you are making this authorization. This authorization. This authorization but no longer than 24 months are considered as a certain event or injury has been proceed to be a certain event and approximate date of this authorization.	ne if so indicated) or for a particular event thorization for an extended period, the ization will remain in effect until (check of onths from the date of signature provided (e.g., "Back injury from April 20 f event):	one):
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