## **Authorization to Release Information**

Patient Name:			
Address:	First		Middle
Date of Birth:	Social Security #_	State	ZIP Code
Telephone #:			
I hereby authorize and request:			
Scott County Physical Therapy		Phone: (50	2) 962 4242
208 Bevins Lane Suite F			2) 863-4242
Georgetown, KY 40324		Fax: (502)	370-9813
To share the following items from	n my Protected Heal	th Information	
X-ray Readings/Reports		rogress Reports	
Daily Notes		take Forms	
Initial Evaluations	Mi		
ALL / ANY records pertain	ning to the above par	tient	
Dates of Treatment:			
			==>
Please list any limitations to this			
WITH:Name of Pe	son or Oracionia Control		
	ison or Organization from whom informal	tion is requested	
Street Address	City	State	ZIP Code
Telephone #	Fax#		
The sharing of this information is	for:		
Coordinating care with MI	) Transferri	ng care to other P'	Т
Patient's personal records	Insurance	Clarification	1
Legal proceedings		ease list	
3 . F	Omer, pre	ASC 11St	
understand that I may refuse to s	ign this authorization	ι.	
understand that I am entitled to C There is a charge for additional co	ONE FREE COPY of pies.	my protected hea	lth information.
understand that I may revoke this Scott County Physical Therapy, ex authorization; or obtained my auth from a third party payer.	cept when SCPT has	already taken act	ion based on my
Jnless previously revoked, this au ignature or at a designated time li	thorization shall expi sted.	re one year from t	the date or
Date	atient / Guardian (if minor)	Relationsh	ıîp
D.t.			