Patient's Authorization to Disclose Medical Records

I, _____, authorize **MOVE PLLC dba Restore Physical Therapy** to release medical information to be used on my behalf to the following:.

Referring Physician's Name: _____

Your Insurance Company _____

Other Physician/Other Insurance: _____

Please ***initial*** the following to authorize:

_____ I consent to treatment by a physical therapist.

_____ I specifically authorize the release of physical therapy records and any physician's orders for therapy, to the parties mentioned above.

_____ I authorize Restore Physical Therapy to bill my insurance company and furnish information to them concerning my treatments.

_____ I assign to Restore Physical Therapy all payments for services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ I understand that I will be billed for any appointments canceled with less than 24 hours notice.

_____ I have been informed that this office's ***Notice of Privacy Practices (HIPPA)*** is available upon request and is on display to review on anytime. I can obtain a copy by request.

May we leave the following information on your answering machine at home or work? (***Please Initial***)
Appointment/Schedule confirmations with date and time? Yes_____ No_____
Financial Information? Yes_____ No_____

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire one year from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Signature of Patient _____

Date _____

(Parent or Guardian if applicable) _____

Date _____

I acknowledge that I was provided with a copy of the *Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the notice.

PATIENT NAME (PLEASE PRINT) _____
DATE _____

PARENT / AUTHORIZED REPRESENTATIVE (IF APPLICABLE) _____

SIGNATURE _____