Rebound
Sports and Orthopedic Physical Therapy, LLC

Medical Records Release Authorization (HIPAA Compliant)

PO Box 110171, Anchorage, AK 99511 PH: 907 341-5555 FAX: 907 341-5755

Patient Information:

Name: _____ DOB: _____ Phone: _____

Address: _____

Authorization:

I authorize **Rebound Sports and Orthopedic Physical Therapy** to release information to:

Name/Organization: _____

Address: _____

Phone: _____ Fax: _____

Information to Be Released (check all that apply):

☐ Entire Record ☐ PT Evaluations ☐ Progress Notes

☐ Billing Records ☐ Imaging/Reports ☐ Plan of Care

☐ Dates of Service: _____

☐ Other: _____

Purpose (check one):

☐ Continuing Care ☐ Insurance/Payment ☐ Legal ☐ At My Request

☐ Other: _____

Expiration (check one):

This authorization expires:

☐ On: _____ ☐ One year from signature ☐ Upon completion of treatment

Acknowledgment:

I understand that: (1) Treatment/payment is not conditioned on signing; (2) I may revoke this authorization in writing at any time except where action has already been taken; (3) Information disclosed may be subject to re-disclosure and may no longer be protected by HIPAA; (4) I may receive a copy of this signed form.

Signature:

Printed Name: _____

Signature: _____ Date: _____

If Personal Representative:

Name: _____ Relationship/Authority: _____

Signature: _____ Date: _____

Clinic Use Only: Date Received: _____ Processed By: _____

Method: ☐ Fax ☐ Secure Email ☐ Mail ☐ In Person