



AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

This authorization complies with 45 CFR § 164.508(c) (HIPAA)

Patient: _____

Patient's Date of Birth: _____

I hereby authorize _____ to furnish, discuss and release all information and records requested below in writing covering findings, treatment rendered, and opinions as to my condition as authorized below to TheraGeri LLC.

Dates of Protected Health Information to be released:

- from _____ to _____
- and for the next 12 months or until I revoke this Authorization, whichever comes first.

Purpose of this Authorization to Release Health Care Information:

- to develop and coordinate my treatment plan
- to communicate contraindications, precautions, progress and/or recommendations for return to work, athletic/sports activities or other functional activities
- to pursue legal/liability claims
- to comply with the patient's request
- Other: _____

Records authorized to be released:

- Examination/Evaluation records
- All treatment records
- Diagnostic tests (MRI, X-rays, CT Scan, EMG/NCV testing, and any other diagnostic tests) in my records regardless of who created the records.
- Other: _____

ACKNOWLEDGEMENTS:

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I may revoke this authorization at any time by executing a written revocation, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to a copy of this authorization and to inspect or copy information disclosed hereunder, pursuant to C.F.R. 164.524.
- I understand that no enrollment or eligibility for benefits, treatment or payment is intended or expected to be conditioned upon this Authorization.

Patient's Signature

Date

Parent or Guardian's Signature

Date



Date: _____

To Whom it May Concern:

Enclosed please find a signed authorization to release protected health information in your possession. **Federal law requires you to respond to this request within 30 days.** Please fax the records to us at 256.444.0819

If you have any questions, feel free to contact us at 256.400.0250. Thank you in advance for your timely attention to this request.

Representative's Signature

Date

Representative's Full Name

Date