SPOONER

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name		**Date of Birth:**	

I hereby authorize Spooner Physical Therapy, its affiliates, medical staff, employees, and their representatives to release my protected health information in the manner listed below, and to the following:

Send by: (choose one): □ Mail □Fax

Send to:

Name:_____

Address_____City_____State_____Zip_____

Phone#_____ Fax#_____

Please send:

□ **All Records**

□ **Healthcare information related to the following treatment, conditions, or dates (please list):**

_____

□**Other**

I understand that my records may contain but are not limited to: history, diagnosis, and/or treatment of HIV (AIDS virus), other sexually transmitted diseases, and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released. This request is a free and voluntary act by me. I understand that I may revoke this authorization at any time to the extent that prior action has not been taken on this authorization. I also understand that my revocation of this authorization must be in writing. I understand that if the organization is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Authorization is valid for one year from the date of signature unless revoked in writing. I have read and understand this consent and I have signed it voluntarily.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Printed Name of Legal Guardian Relationship to Patient if Applicable