Medical Information Release Form
(HIPAA Release Form)

Name: ______________________________________ **Date of Birth:** ______________________

Release of Information

( ) I authorize the release of all medical information rendered to me by Results Physical Therapy. This information may be released to:

( ) Spouse___________________________

( ) Child(ren) _______________________

( ) Other____________________________

( ) Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call **( )** my home **( )** my work **( )** my cell number

If unable to reach me:

( ) You may leave a detailed message.

( ) Please leave a message asking me to return your call.

( ) You may send a text message.

The best time to reach me is (day) ______________________between (time) _________________

I authorize email communication to the following email address: __________________________

Signed: ____ **Date:** ________________________