

**AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION**

Please REQUEST medical information FROM:

Clinic/Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Please SEND medical information TO:

Village Physical Therapy  
5425 W Spring Creek Pkwy, Suite 270  
Plano, Texas 75024

Source One  
5601 Bridge St, Suite 500  
Fort Worth, TX 76112

Source One  
8080 Independence Pkwy, Suite 110  
Plano, Texas 75025

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____	_____ - _____ - _____	_____ / _____ / _____
Name of Patient	Social Security Number	Date of Birth
_____	_____	_____
Address	City	State      Zip Code
_____	_____	_____
Home Phone	Work Phone	Cell Phone

DURATION: This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_(enter date) or for ninety days from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

CD or electronic version is preferred.

\_\_\_ Entire medical records \_\_\_ History and Physical \_\_\_ Chart Summary \_\_\_ Labs \_\_\_ Radiology \_\_\_ Pathology

\_\_\_ Other (please specify) \_\_\_\_\_

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:

\_\_\_ Physician or Health Care Facility \_\_\_ Legal \_\_\_ Personal \_\_\_ Other (please specify) \_\_\_\_\_

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

\_\_\_\_\_  
Signature of patient or legal representative      Date      Relationship

AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Please REQUEST medical information FROM:

Village Physical Therapy  
5425 W Spring Creek Pkwy, Suite 270  
Plano, Texas 75024

Source One  
5601 Bridge St, Suite 500  
Fort Worth, TX 76112

Source One  
8080 Independence Pkwy, Suite 110  
Plano, Texas 75025

Please SEND medical information TO:

Clinic/Physician: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

I hereby authorize the above-mentioned provider to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above. I also understand this information may contain information relating to Acquired Immunodeficiency Syndrome (AIDS) or infection with Human Immunodeficiency Virus (HIV), mental health, and alcohol and /or drug abuse.

Release and/or disclose records and information regarding:

_____	_____ - _____ - _____	_____ / _____ / _____
Name of Patient	Social Security Number	Date of Birth
_____	_____	_____
Address	City	State      Zip Code
_____	_____	_____
Home Phone	Work Phone	Cell Phone

DURATION: This authorization shall become effective immediately and shall remain in effect until \_\_\_\_\_(enter date) or for ninety days from the date of signature if no date entered.

REVOCAION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

PLEASE SPECIFY RECORDS TO BE RELEASED AND/OR DISCLOSED:

CD or electronic version is preferred.

\_\_\_ Entire medical records \_\_\_ History and Physical \_\_\_ Chart Summary \_\_\_ Labs \_\_\_ Radiology \_\_\_ Pathology  
\_\_\_ Other (please specify) \_\_\_\_\_

I request that the health information release and/or disclosed pursuant to this authorization be used for the following purposes only:

\_\_\_ Physician or Health Care Facility \_\_\_ Legal \_\_\_ Personal \_\_\_ Other (please specify) \_\_\_\_\_

A copy of this authorization is valid as an original. I have the right to receive a copy of this authorization. The copy is for me to keep. I understand that there may be a fee for preparing and furnishing this information.

Signature of patient or legal representative \_\_\_\_\_ Date \_\_\_\_\_ Relationship \_\_\_\_\_