



Authorization To Release Medical Information

This will authorize _____ to release to St. Francis Physical Therapy information from the medical record(s) maintained regarding all injuries, medical history, and physical condition.

The information to be disclosed is:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Doctors Progress Notes |
| <input type="checkbox"/> EEG's, EMG's, EKG's, MRI's, CT Scans | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Occupational Therapy Notes | <input type="checkbox"/> Doctor Statements |
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Other (Specify) |

The information is needed to assist in development of a physical therapy plan of care.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose this consent will automatically expire without my express revocation.

A photocopy or fax copy of this authorization shall be considered as valid as the original.

(Signature of Patient/Guardian)

Date: _____

Patient Name: _____

Date of Birth: _____

SS#: _____