POST PHYSICAL THERPAY
Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____
Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care Military Social Security/Disability Insurance
Personal Use School: _____ Legal Purposes
Other: _____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physica l Consultation Report Emergency Room Record Operative Reports
Discharge/Death Summary Face Sheet Lab/Path Reports X-Ray Reports/Images
Other: _____

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include, but is not limited to, history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Signature: _____ _____
Patient or Legally Authorized Representative Printed Name of Patient or Authorized Representative

Date: _____ Relationship to Patient:_____

Dear Patient:

To obtain a copy of your medical records, please complete the enclosed authorization form, sign it and return to POST Physical Therapy by email info@postpt.com, fax 617-731-4162 or mail to:

POST Physical Therapy
235 Cypress Street, STE 110
Brookline, MA

Please note that for each record request there is a processing fee, an amount established by state law. When you return the authorization form, we ask that you send a check payable to POST Physical Therapy, pay online (postpt.com/web/pay-online) or provide your credit card information in the section below. When we receive the signed authorization form we will process the request as quickly as possible. If you have any questions, please call and ask to speak with the clinic manager.

Thank you,

Vanessa Connoly

Clinic Operations Manager

Credit Card #:_____

Billing Zip Code:_____

Expiration Date:_____

Print Name on Card:_____

Signature of Cardholder:_____