Midwest Physical Therapy LLC

Authorization to Release Personal Health Information

1. Patient Information	Name:_____ Birthdate: _____ Address: _____ _____ Phone number: _____
2. Health Information to be Released: (circle one) **TO** **FROM**	Midwest Physical Therapy 2801 S Wayzata Blvd, Suite 200 Minneapolis, MN 55405 Ph: 612-707-0169 Fax: 612-465-1603
3. Health Information to be Released: (circle one) **TO** **FROM**	Clinic/Person: _____ Address: _____ _____ Phone: _____Fax: _____
4. Information to be Released:	_____All medical treatment records from ___/___/___ to present. *Excludes chemical dependency and mental health records.* _____Radiology Reports/Imaging _____Other information _____
5. Purpose of Release:	_____Patient's request _____Treatment/ continuation of care _____Legal action _____Insurance and/or payment requirement
6. Consent:	I understand that by signing this form, I am requesting my health information be shared as specified in sections 2 and 3. I may stop this consent at any time by written notification to the entities named in sections 2 and 3, effective upon their receipt of my request. I understand that shared health information may be re-disclosed by the third-party receiving it and may no longer be protected by HIPAA privacy laws. **This consent will end one year from the signed date unless I revoke My consent in writing.**
7. Authorized Signature:	_____ _____ Signature of patient Date _____ _____ Or, Signature of patient representative Date _____ Printed name of representative and relationship to patient

A photocopy of this authorization is as valid as the original.