APMI
Physical Therapy and Fitness Center

Authorization to Release PHI (Protected Health Information) Access, Inspect, and/or Copy

Patient's Name: _____ Date of Birth: _____/_____/_____

SSN: _____ Previous Name: _____

Practice Name: _____

I request and authorize the above listed practice to release health care information of the patient named above
Copying Charges May Apply

Name: _____

Address: _____

City/St: _____ Zipcode: _____

This request and authorization applies to health care information relating to the following treatment, condition or date of treatment: _____

_____

Or _____ all health care information

Or _____ Other: _____

Once my practitioner gives out the information that I want released, I know that my practitioner has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

_____

Signature of patient or patient's authorized representative Date

_____

Relationship or status if signed by parent, legal guardian, personal representative, etc.

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