# Authorization for Disclosure of Health Information

**Patient Name:** ________________________________________________ **DOB:** __________________

**Full Address:** ____________________________________________________________________________

**Previous/Maiden Names:** __________________________ Phone Number: _______________________

**Email:** ______________________________________________________________________________

| **Release Information From:** |
|---|
| Name/Facility: |
| Address: |
| City/State/Zip: |
| Phone: |
| Fax: |

| **Release Information To:** |
|---|
| Name/Facility: |
| Address: |
| City/State/Zip: |
| Phone: |
| Fax: |

This Request and Authorization applies to:

☐ Medical Records relating to the following treatment, condition: __________________________________

☐ All Medical Record information

☐ Other: ___________________________________________________________________________

**Date information desired by:** ___________________________________

Delivery Method: ☐ Fax (to the number listed above) ☐ Mail (to the address of the facility listed above)

**Service Dates requested:**

From: ______________ To: _________________ ☐ Any future notes (within 1 year)

By my signature below, I am authorizing Apex Physical Therapy & Wellness Center to release the records I specified above. This authorization expires one year from the date of my signature unless I specify differently.

**Signature:** ___________________________________________ **Date:** _______________________

**Parent/Guardian Signature** (if patient is under 18 years of age) _________________________________________