# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**Patient name: _____ Date of Birth: ___ ___/___ ___ / ___ ___ ___ ___**

**Specific Medical Condition(s): _____**

**Specific dates of service/timeframe(s): _____**

**Purpose of Disclosure and Release Procedure:** To minimize cost and prevent delays, please limit your request to the minimum documents necessary to achieve your objective. For your convenience, commonly requested records 'packages' are outlined below. If neither option meets your need, please fill out the 'Other Purposes' section.

**[ ] For Continued Treatment or Consultation with another Healthcare Provider:**

Includes Evaluations/Progress Notes Faxed directly to the provider. - No charge
Provider name: _____
Provider FAX number: (__ __ __ ) ___ ___ ___ - ___ ___ ___ ___

**[ ] For Billing/Claims/Insurance:**

Includes Evaluations/Progress Notes, Billing Ledger, and All Daily Notes
[ ] Email - $15.00 fee Email address: _____
[ ] Fax - $15.00 fee Fax number: (__ __ __) __ __ __ - __ __ __ __
[ ] Hard copies mailed - $20.00 fee
Name of recipient: _____
Address: _____ - _____
City: _____ State: ___ ___ Zip code: _____
[ ] Hard copies picked up - $15.00 fee
Call me at (__ __ __) __ __ __- __ __ __ __ when records are ready to be picked up at 2145 The Alameda San Jose, CA 95126
Release the above records to: [ ] myself or [ ] _____
(Anyone picking up records, including the patient must show photo ID)

**[ ] Other Purposes of Disclosure/Custom Records Package:**

Purpose of disclosure: _____
Type of Records:
[ ] Evaluations/Progress Reports [ ] Daily Treatment Notes [ ] Appointment Logs [ ] Billing records
[ ] Other (specify): _____

Method of Disclosure: (choose one)
[ ] Email - $15.00 fee Email address: _____
[ ] Fax - $15.00 fee Fax number: (__ __ __) __ __ __ - __ __ __ __
[ ] Pick up - $15.00 fee
Please call me at (__ __ __) __ __ __- __ __ __ __ when records are ready to be picked up at 2145 The Alameda San Jose, CA 95126
Release the above records to: [ ] myself [ ] _____
(Anyone picking up records, including the patient must show photo ID)
[ ] Mail - $20.00 fee
Name of recipient: _____
Address: _____ --_____
City: _____ State: ___ ___ Zip code: _____

## Agreement:

Initial to confirm that you agree and understand that:

_____MORE responds to record requests in the order received and has 15 days from receipt of a properly executed release to produce records.

_____This authorization shall become effective immediately and shall remain in effect until (date): _____ (or no longer than two years from date of signature.)

_____I have the right to revoke this authorization at any time provided I do so in writing, except to the extent that MORE Physical Therapy, Inc. has already used or disclosed the information in reliance on this authorization.

_____The information disclosed above may be re-disclosed by the recipient to additional parties and no longer protected for reasons beyond MORE's control.

_____I am required to pay all fees associated with producing the above records *prior to* receiving them.

_____ _____

*Patient's or Legal Guardian's Signature* *Date*

_____

*Name of legal guardian*

_____

*Legal guardian's relationship to patient*

07/18 ef