MAJERUS & CO. PHYSICAL THERAPY
AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

_____ Date of Birth:_____
(PRINT name of patient)

Information to be released **from:**

_____
(Name of designated Facility or Provider)

_____
(Street Address)

_____
(City, State and Zip Code)

_____
(Phone and/or Fax Number, if applicable)

Information to be released **to:**

_____
(Name of Patient, designated Person, Facility of Provider)

_____
(Street Address, if applicable)

_____
(City, State and Zip Code ,if applicable)

_____
(Phone and/or Fax Number, if applicable)

Information to be released:

By Initialing in the spaces below, I specifically authorize the disclosure of the following health information and records.

_____ Chart Records developed between _____ to _____ (Insert start & end dates)

_____ Other: _____ (Specify information requested)

_____ Billing record (Note to Patient/Legal Representative: This will be mailed to you as we do not have billing records on site)

Purpose for which disclosure is being made:

☐ Personal ☐ Medical ☐ Insurance ☐ Legal ☐ Other:_____
(specifiy reason)

Patient Authorization:

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 this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked, this authorization will expire within 90 days. To revoke this authorization, please send a written statement to Joint Ventures Therapeutics, PC, d/b/a Majerus & Co. Physical Therapy, 16219 SE 12th St, #100, Vancouver, WA 98683

SIGNATURE:_____
(Patient or Personal/Legal Representative (Next-of-Kin or Legal Guardian to Sign Only If Patient is a Minor, Legally Incompetent or Deceased)

PRINT NAME:_____ DATE:_____

Relationship to Patient of Personal/Legal Representative Signing: _____

For Office Use only: [ ] Patient's or Legal Representative's Personal Identification Verified