Authorization for Release of Patient Information

Patient Name: ____ Phone Number: ___________________________

Other Names Used: _______________________________________ DOB: ___/___/_____ SS#: _____-_____-________

Address: ____

I, the undersigned, authorize the release of the information specified below from the medical record(s) of the above-named patient.

______ Release to: Lightsey Physical Therapy
2651 Boonville Road, Suite 115
Bryan, Texas 77808
Phone: (979) 446-0422
Fax: (979) 446-0433

______ I hereby authorize Lightsey Physical Therapy to release information to:

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I specifically authorize the use and disclosure of the following PHI (select type and note the period of time you are requesting).

___ History and Physical ______________________

___ Radiology Reports ________________________

___ Verbal Communication regarding health care

___ Other _________________________________

___ Operative Reports ________________________

___ Office Notes _____________________________

___ Medications _____________________________

___ Emergency Records _______________________

I understand I may revoke this consent at any time except to the extent that action has already been taken in reliance on it.

Patient or Guardian Signature: _________________________________ Date: ___/___/_____

Printed Name: ____ Relationship to patient: ___________________