Core Physical Therapy
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Portland, OR 97212
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AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

This authorization must be dated and signed by the patient or by a legally authorized person.

I authorize Core Physical Therapy to + **OBTAIN** and/or + **RELEASE** a copy of the following medical information for: _____(name of patient) **DOB:**_____

Practitioner Name: _____

Practice: _____

Phone Number : _____ Fax Number: _____

The information will be used on my behalf for review of past medical history and for the following purpose: (if any indicated) _____

By initialing the spaces below, I specifically authorize the release of the following medical records, if such records exist:

____All Medical Records
____Transcribed Hospital Records
____Most Recent Five Year History
____Emergency and Urgent Care Records
____Diagnostic Imaging Reports
____Laboratory Reports
____Pathology Reports
____Clinician Office Chart Notes
____Other _____

The following items must be initialed to be included in other documents.

____HIV/AIDS Related Records
____Mental Health Information
____Genetic Testing Information
____Drug/Alcohol Diagnosis, Treatment, or Referral Information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe: _____
_____

This authorization is for all records unless otherwise indicated below.

____This authorization is limited to records regarding the following treatment: _____
____This authorization is limited to records from the following time period: _____
____This authorization is limited to a worker's compensation claim for injuries on: _____(date)

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonable needed to complete the request.

_____ _____
(Date) (Signature of Patient, or Parent or Guardian of patient)