

Pickup Instructions_____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME:				
	DOB: / /		PREVIOUS NAME(S):		
2. RELEASE MY	FACILITY NAME:				
RECORDS					
FROM	DR. NAME:				
3. SEND MY RECORDS TO	NAME:		ATTN TO:	ATTN TO:	
	ADDRESS:				
	CITY:		STATE:	ZIP:	
	PHONE:		FAX (For Continuing	FAX (For Continuing Care ONLY):	
	Email: (Only if you want records sent via encrypted email)				
	DATE(S) OF SERVICE:				
4. TYPES OF RECORDS	 □ All Health Records (not including billing or imaging) □ Physical Therapy Notes □ Nutritional Counseling Notes □ Other □ Billing Records 				
	For verbal disclosure, check here:				
5. VERBAL DISCLOSURE	"Verbal disclosure" authorizes Infinite Health Collaborative to discuss my care with the person(s) indicated in this section:				
6. REASON FOR REQUEST	□ Personal Use □ Insurance □ Workers Compense □ Disability □ Legal □ Continuing Care				
7. RETURN COMPLETED FORMS TO:	MAIL TO: Viverant Physical Therapy 7825 3 rd St N, St 105 Oakdale, MN 55128 * Records will be mailed to the perso		FAX TO: 678-981-6769 EMAIL TO: recordsrelea DROP OFF: Viverant Please allow up to 2	ase@i-Health.com hysical Therapy	
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	 I may revoke this authorization at any time by notifying the facility identified above in writing. By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. There may be a fee for release of this information and I may be responsible for that fee. I am authorizing the release of my personal protected health information from any i-Health facility unless otherwise specified above Treatment will not be denied to me if I do not sign this form. This authorization will expire one year from the date I sign on this form unless specified: i-Health is a multispecialty practice including, and without limitation, the clinic above. Your i-Health record will be released, unless you otherwise specify in writing SIGNATURE: PRINT NAME: *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form. 				

^{*}Electronic Typed Signatures cannot be accepted*