3507 Post Street Clinton, NY 13323
315.557.6848
megamotionpt@gmail.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____
DATE OF BIRTH: _____
ADDRESS: _____
CONTACT NO.:_____

I hereby authorized to disclose my health information to:

Megamotion Physical Therapy Clinic of 3507 Post St. Clinton, NY 13323

Telephone No. : 315.557.6848 Email: megamotionpt@gamilcom

It is my intent that the use of information furnished is prohibited for any purpose other than states above and the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to Health Information Services Department. I understand that this revocation will not apply to the extent that Megamotion Physical Therapy has already taken action in reliance to this authorization. This authorization will automatically expire 120 days from the date of my signature, unless I otherwise specify that this authorization will terminate on the following date, or concurrent with the following event or condition: _____.

PATIENT SIGNATURE:_____ DATE:_____

If legal representation required, please sign below and state relationship and authority to do so and attach the document of authority.

LEGAL REPRESENTATIVE NAME:_____
LEGAL REPRESENTATIVE SIGNATURE:_____
RELATION TO THE PATIENT:_____DATE:_____