

KLAFF SPORTS PHYSICAL THERAPY, INC.
Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

PATIENT INFORMATION IS NEEDED FOR:

Continuing Medical Care _____ Military _____ Social Security/Disability _____
Insurance Personal Use Other: _____ Legal Purposes School _____

INFORMATION TO BE RELEASED OR ACCESSED:

History & Physical Consultation Reports

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

Name: _____

Address: _____

Phone: _____

Fax: _____

FROM:

Klaff Sports Physical Therapy, Inc.
1501 Sulgrave Avenue, Suite 307
Baltimore, MD 21209
(443) 595-7848

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

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 the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____

Signature: _____

Patient or Legally Authorized Representative

Printed Name of Patient or Legally Authorized Representative