Eminence Physical Therapy
Elevating Function to New Heights

EMINENCE PHYSICAL THERAPY MEDICAL RECORDS RELEASE FORM
($50 ADMINISTRATIVE FEE)

Patient Name:

First_____ Middle_____ Last_____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Patient Type:
___ Self
___ Patient's Authorized Representative

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INFORMATION REQUESTED

***Specific Records Requested:**

___ Patient Intake Forms
___ Physical Therapy Prescription
___ Physical Therapy Evaluation
___ Physical Therapy Progress Notes
___ Physical Therapy Discharge Summary
___ Limb Volume Measurement Forms
___ Compression Garment Measurement Forms
___ Other: _____

Name of Company Where The Patient Was Treated: Eminence Physical Therapy, LLC

Company Location: Duluth, GA 30096

Company Phone Number: 706-631-1030

Company Fax Number: 770-818-5878

Date(s) of Service: (Identify the date(s) of service or date ranges requested including month and year: _____

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RECORD RELEASE

Medical records are to be released to the following individual or company:

Name: _____

Phone Number: _____

Fax Number: _____

Email Address: _____

Mailing Address:

_____
_____
_____

Delivery Method:

___ Electronic (Email)

___ Mail -USPS

___ Fax

***Reason for Request**

___ Continued Medical Care at Another Entity
___ Legal Purposes
___ Insurance Purposes/Claims
___ Personal Interest

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CONSENT

I have read and understand the following statements:

- I understand that this Authorization will expire 60 days after I sign this form.
- I understand that Eminence Physical Therapy, LLC. may be allowed by law to refuse to allow access to or disclosure of all or part of my protected health information. If access or disclosure is denied or refused, Eminence Physical Therapy will not release the information as requested in this Authorization, and I will be notified of the denial/ refusal in writing.
- I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that Eminence Physical Therapy, LLC will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.
- I understand that I may revoke this Authorization at any time by notifying Eminence Physical Therapy, LLC. in writing, but if I do, it will not have any effect on any actions Eminence Physical Therapy took before it received the revocation.
- I understand that there is potential for information disclosed based on this authorization to be subject to re-disclosure by the recipient and no longer be protected by the Privacy Rule.
- I understand that requests will be subject to a copying and/or release fee of **$50** to cover administrative costs for the release of information.

By checking Yes, you agree to abide by the Terms of Service outlined above

___ Yes

Signature of Patient or Authorized Representative: _____

Relationship of Authorized Representative to Patient: _____

Printed Name: _____

Date of Signature: _____