



PHYSICAL THERAPY, INC
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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED PARTY

Patient Name: _____ Patient Date of Birth: _____
Provider Name: _____

Designated Party: _____ Designated Party: _____
Relationship to Patient: _____ Relationship to Patient: _____
Address: _____ Address: _____
Phone: _____ Phone: _____
Fax: _____ Fax: _____

The information will be used or disclosed for the following purposes:

___ At the request of the individual ___ Other _____

This Authorization grants permission to the Designated Party (ies) named above to:

- ___ have access to my medical record information
- ___ have access to my billing & insurance information
- ___ have access to any test results
- ___ make or confirm appointments
- ___ other, please specify _____

I authorize Summit Physical Therapy, Inc. to use and disclose my health information as described in this authorization.

The patient or the patient's representative must read and initial the following statements:

- I understand that this authorization will: (Must check one)
 - ___ expire 1 year from the date signed by the patient or patient's representative; or
 - ___ only when revoked by the patient
- I understand that I may revoke this authorization at any time by notifying in writing the above named Provider; however, if I do revoke the authorization, it will not have any effect on any actions taken by Summit Physical Therapy, Inc. prior to their receipt of the revocation
- I understand that this authorization is voluntary
- I understand that once this information is released to the Designated Party (ies), the released information may no longer be protected by federal privacy regulations
- I understand that my treatment cannot be conditioned on whether I sign this authorization
- I understand that the fees for printed/electronic documents are as follows:
 - Paper copies: 0-50 pages \$5.00; 51-100 pages: \$7.00; Over 100 pages: \$10.00
 - Thumb drive: \$5.00

Signature of patient or patient's representative
(Form MUST be completed before signing or will not be valid)

Date

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OFFICE USE ONLY

Signature

Date Received