Authorization to Release Medical Information

Name of Patient: _____ Date of Birth: _____

I understand that my family members, friends, and co-workers may ask questions about my medical condition over the telephone or in person. I also understand it is a breach of physician-patient confidentiality for therapists to discuss my medical information in any way with anyone without my expressed written consent. In signing this form, I am designating the parties below with whom I wish **Meyers Physical Therapy** to be able to discuss my medical condition.

I understand this form will be updated every calendar year. If I change my mind regarding the release of information to any of the listed people, it is my responsibility to inform **Meyers Physical Therapy** in writing of my decision.

In accordance with the above, I _____, here by allow **Meyers Physical Therapy** to discuss with and release my medical information to the following individuals:

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I understand that certain information cannot be released without specific authorization as required by federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information:

_____ Information regarding the patient's diagnosis and treatment
_____ Billing and payment information
_____ Appointment and schedule information

Signature of patient / personal representative: _____
Date: _____