AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

First Name:___________________________Last Name:___________________ Date of Birth: __/__/____

Previous/Other Name: ____

I request and authorize Inspire Physical therapy ("IPT") to use, disclose, or release my protected information (medical records) specified below:

____
Name of Person or Company

____
Address: Street City State Zip Code

INFORMATION REQUESTED: (Check applicable box(es), giving the dates of approximates dates covered by each)
____Complete Medical Record
____Complete Medical Record & Financials
____Complete Medical Record during date span:__/__/____to__/__/____
____Financials ONLY

PURPOSE for which the information is being released (check one)
____Personal____Legal____Insurance____Consultation with Specialist
____Permanent transfer to another provider
____Physical Therapy Initial Evaluation & Progress Reports ONLY
____Other____

I UNDERSTAND THAT:

- The information released is confidential and must be used for the purpose that it was requested for; however, once this information is disclosed, the information may be subject to re-disclosure and may no longer be protected by federal and state confidentiality laws.
- Inspire Physical therapy will treat me even if I decline to sign this authorization.
- Upon request, I can inspect or obtain a copy of the information I am authorizing to be released. A fee for the costs of processing this request may be charged.
- I can revoke this authorization at any time by submitted in writing to: Inspire Physical Therapy 14780 SW Osprey Drive, Suite 270, Beaverton, OR. 97007. This will not apply to any previously released information. I understand that this will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization expires at time of discharge or effective this date: ______ / _____ / ______

Signature: ____ Date: ___________________
(Parent or Legal Guardian must sign if patient is under 18 years of age)

Printed Name of Parent/Legal Guardian for Minor:____

Relationship to Patient: (If patient is under age of 18): ____Mother____Father____Legal Guardian