BURGER PHYSICAL THERAPY

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Info					
Name				Date	
Address				Date of Birth	
Phone		Email			

Authorization to Release & Or Disclose My Medical Records to a 3rd party

The undersigned hereby authorizes and requests BURGER PHYSICAL THERAPY AND REHABILITATION AGENCY, INC. to provide or disclose medical records information to _____ and grant access to my medical records or medical records information for the purpose of review and examination. Medical records information regarding my illness or injury, consultation, diagnostic tests, and treatment is authorized for all instances unless duly noted on the exemptions section below. This release is approved for insurance, legal, athletics and any other individual whose name is authorized in this section.

NAME: _____ DATE: _____

(If signed by personal representative, state relationship and authority to do so.)

Mail Records to: ☐				Email Records to:☐	
Pickup Records ☐	Disclose Records to: ☐	Fax Records to: ☐		_____ Initial	*I understand that there is a risk to receive my records electronically to an unencrypted, unsecure email.*

Request for My Medical Records

The undersigned hereby authorizes and requests BURGER PHYSICAL THERAPY AND REHABILITATION AGENCY, INC. to provide my records to me.

NAME: _____ DATE: _____

(If signed by personal representative, state relationship and authority to do so.)

Mail Records to: ☐			Email Records to:☐	
Pickup Records ☐	Fax Records to: ☐		_____ Initial	*I understand that there is a risk to receive my records electronically to an unencrypted, unsecure email.*

Exemptions: Request Is limited to marked sections below *(Check all that Apply)*

☐	Confined to records regarding admission and treatment for the following medical condition or injury: On or about this date_____
☐	Any and all records for the period from _____to _____
☐	Billing reports for the period from _____to _____
☐	Confined to the following specified information: _____

ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED EXEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE. *FEE FOR COPY OF RECORDS IS $0.25 CENTS PER PAGE PLUS POSTAGE IF RECORDS ARE MAILED. Inspection and Copying of Patient Records and Related Material – Cal. Health & Safety Code § 123110 - ANY REVOCATION OF THIS REQUEST MUST BE SUBMITED IN WRITING.