IMPACT
PHYSICAL THERAPY
SPORTS RECOVERY

Authorization for Release of Patient Health Information

Last Name: ________________________ First Name: ______________________________

Date of Birth: ________________ Phone Number: ___________________________

I authorize IMPACT Physical Therapy to disclose my protected health information (PHI) in the manner described below:

☐ In-Person

☑ E-mail address: RECDEP.COM

☐ US Mail:

Person/Organization: RECORDS DEPOSITION SERVICE

Address: PO BOX 5054

City/State/Zip: SOUTHFIELD, MI 48086-5054

Dates of Service: (Check One)

☐ Please provide a complete copy of my medical records for all dates of service

☐ Please provide a copy of my medical records for services from __________ to ____________

Records to be Released: (Check all that apply)

☐ All medical records ☐ Progress Notes ☐ Itemized Billing

☐ Initial Evaluation ☐ Discharge Summary ☐ Other: _________________

☐ Daily Notes ☐ Home Exercise Programs

This authorization will be used for: (check all that apply)

☐ Patient Request ☐ Social Security/Disability ☐ Continuation of Care ☐ Attorney

☐ Insurance ☐ Worker's Compensation ☐ Other: _________________

I understand that my health care will not be affected if I do not sign this form.

I understand that I may revoke this authorization in writing to IMPACT Physical Therapy.

I understand unless otherwise revoked, this authorization will expire one (1) year from the date signed.

I understand that I have the right to review my health information before release. I also understand that I have a right to receive a copy of this authorization.

I understand there may be a cost associated with processing copies of medical records.

Patient/Guardian Signature: ___________________________________ Date: _____________

Patient/Guardian Name (Print): ________________________________ Staff Initials: ________