



# Timberlane

## PHYSICAL THERAPY

### AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

1. I hereby authorize \_\_\_\_\_ to use or disclose the following  
(Name of Hospital/Physician)  
protected health information from the medical records of the patient listed below. I understand that information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

2. Patient Information:

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

3. Information to be Disclosed to:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip \_\_\_\_\_

4. Disclose the following treatment dates: \_\_\_\_\_ to \_\_\_\_\_

(Check the applicable request)

Complete Records     Consult     Physical Therapy  
 Abstract     Outpatient Reports     Emergency Reports  
 Admission Summary     X-Rays     Office Notes  
 History & Physical     Pathology     Other

\*If "Other", please specify: \_\_\_\_\_

---

5. The above information is for the following purpose(s):

Legal     Insurance     Personal     Other

6. I understand that I may **revoke this authorization** at any time by requesting such of the above Referenced hospital/physician practice in writing unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

7. This authorization expires on (upon) \_\_\_\_\_

8. \_\_\_\_\_ 9. \_\_\_\_\_  
Signature of Patient or Representative    Date

Printed Name of Patient or Representative

Relationship to Patient, or  
Authority to Act for Patient  
(If signed by Representative)