LEADING EDGE
Physical Therapy

REQUEST FOR PROTECTED HEALTH INFORMATION / PATIENT AUTHORIZATION FOR RELEASE

PATIENT NAME _____

DOB _____ SS# (OPTIONAL) _____

PATIENT PHONE NUMBER _____

TREATMENT DATES TO BE RELEASED _____

PERSON(S) / ORGANIZATION AUTHORIZED TO MAKE THE DISCLOSURE

LEADING EDGE PHYSICAL THERAPY
4406 S FLORIDA AVE, #16
LAKELAND, FL 33813 863-688-1800

RELEASE INFORMATION TO (Please complete entire address with fax if going to another doctor)

NAME _____

ADDRESS _____

CITY-STATE-ZIP _____

PHONE _____

FAX _____

PURPOSE OF RELEASE - [ ] INSURANCE [ ] LEGAL [ ] CONTINUING CARE [ ] PERSONAL

I understand that the purpose of this authoizaiton is for the use and/or disclosure of my protected health information (PHI) and that it may obtain information that is protected under state laws and federal regulations. I understand that once the above information is disclosed it may be subject to re-disclosure and will no longer be protected by Privacy Protection Rules. I understand that I have the right to revoke this authorization at any time and that my recocation must be submitted to the HIM Department. I understand that my recovation is not effective to the extent that the persons or organizations in which I have authroized to use and/or disclose my protected health infromation have acted in reliance upon this authorizaiton. I understand that I may refuse to sign this authorization and my refusal to sign will not affect my ability to recieve treatment, payment enrollment, or eligibility for benefits. I understand that I will be given a copy of this authorization upon my signature if requested.

I hereby authorize this medical facility and/or ScanSTAT Technologies to disclose/release medical records and other information obtained in the course of my diagnosis and/or treatment. I agree to pay copy charges if applicable.
I hereby release this medical facility and/or ScanSTAT Technologies from any liability which may result from this disclosure of confidential medical information or which may arise of the result of the use of the information contained in the information released.

This information may include Medical/Surgical, Psychiatric, Substance Abuse and HIV/AIDS information. I authorize that this information may be faxed when applicable.

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
PATIENT'S REPRESENTATIVE SIGNATURE AND AUTHORITY TO SIGN DATE