La Plata Physical Therapy & Wellness, Inc.

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBER

Many of our patients allow family members (ie: spouse, parent(s), guardian(s), children or others) to call and discuss medical information such as appointments, medical records and bills. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have any of your medical information released to family members, please complete the form below.

This is NOT a required form. You have the right to remove this authorization at any time by so requesting in writing.

I, ____, date of birth _________________________,

Authorize representatives of La Plata Physical Therapy & Wellness, Inc. to share and/or release information to:

1) ____ Relationship _____________________
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

2) ____ Relationship _____________________
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

3) ____ Relationship _____________________
(check all that apply)

___ Appointment Information ___ Bills ___ Medical records ___ Any/All Information

I understand that I have the right to change this authorization, at any time, by sending a written notification to this office.

____ **________________________**

(Signature) **(Date)**