3217 Summit Square Place, Suite 100 Lexington, KY 40509
859.263.8080, FAX 859.263.8775
www.advantageptlex.com.com

Medical Records Release Authorization Form

I,_____, hereby authorize E&R Enterprises, PLLC dba Advantage Osteopractic Physical Therapy (herein referred to as "AOPT") to use and/or disclose my protected health information described below to: _____

My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose): _____

_____

_____

This authorization for use and/or disclosure applies to the information described below (mark those that apply):

- ☐ Any and all records in the possession of AOPT including mental health, HIV, and/or substance abuse records. (Cross out any item you do not authorize to be released.)
- ☐ Itemized Billing Statement.
- ☐ All records covering the period of time ___/___/_____ to ___/___/_____
- ☐ Records regarding treatment for the following condition or injury _____
- ☐ X-Rays ☐ MRI ☐ CD ☐ Other (please specify and include dates)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Manager- Health Information. I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that I do not have to sign this authorization and that AOPT may not condition treatment or payment on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information.

This authorization expires on (please list a specific date or event) _____, or 1 year after signature.

I certify that I have received a copy of this authorization.

_____ _____

Signature of Patient or Personal Representative *Date*

_____ _____

Printed Name of Patient or Personal Representative *Description of Personal Representative's Authority*

_____ _____

Date of Birth *Social Security #*