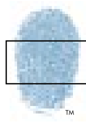

mti physical therapy

PROVIDING ONE-TO-ONE CARE

# MEDICAL RECORDS RELEASE

I authorize **Manual Therapy International** to use and/or disclose a copy of the specific health and medical information identified below for **(name of patient)** ..........................................................................................

to **(name)** ....................................................................... **(address of recipient)** ................................................

for the following purposes: **(describe each purpose of use/disclosure)**.................................................................

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List the information that is to be used:..........................................................................................

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1. I understand that if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

2. **[If applicable]** I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

3. I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment, or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

4. Finally, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. Submit the revocation of authorization to the clinic that you made the original request.

5. This authorization expires.........
 **(applicable date or event)**

Signature of Patient or Personal Representative

Date

Print Patient's Name

Print Name of Personal Representative (if applicable)

Relationship to Patient

Clinic Representative/Witness

Date

***A copy of this signed form is to be provided to the patient.***