PAIN & MOVEMENT SOLUTIONS

Medical Records Department
511 National St. Suite #101 Belle Fourche, SD 57717

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

_____ (*Patient name*) is requesting the release of health information to:

_____ *(Name, Position, or Department receiving disclosure*)

_____ *(Name of organization receiving disclosure)*

_____*(Address of organization receiving disclosure)*

_____*(Phone number of organization receiving disclosure)*

The purpose of the disclosure: ("Request of the Individual" is sufficient for patient-initiated releases**) _____**

_____

The information to be disclosed relates to service dates beginning _____ and ending _____.

_____ Entire Physical Therapy Medical Record _____ Specific Therapy/Medical Information as Noted Below

---

_____I authorize the staff of **Pain & Movement Solutions** to disclose/release the health information noted above.

CONDITIONS and NOTIFICATIONS:
This authorization for release of information expires 12 months from the date of patient's signature. You may revoke this authorization at any time by writing ***Pain & Movement Solutions****, Attention: Medical Records, 511 National St. Suite #101 Belle Fourche, SD 57717.* However, such notification will not affect any actions taken in reliance on this authorization prior to the time of receipt of the revocation.

You may inspect or request a copy of the health information to be used or disclosed, consistent with federal law. **Note:** There may be a processing fee charged to the patient to cover labor, copying, and supplies used to reproduce medical records.

You will be provided with a copy of this signed authorization.

SIGNATURES:
I hereby authorize the use or disclosure of the personal health information as described above. I understand that I may refuse to sign this authorization, that this authorization is voluntary and that my health care and the payment for my health care will not be affected if I do not sign this form. I also understand that if the individual or organization authorized to receive the information is not a health plan or health provider, the released information may no longer be protected by federal privacy regulations and, therefore, may be subject to re-disclosure.

Patient Name (PRINT)_____ SS# _____ DOB _____

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name if Personal Representative: _____

Relationship of Representative to Patient: _____

Department Representative Name/Title: _____ Date: _____