mountain center

physical therapy • performance fitness • functional health

Release of Information

PATIENT'S NAME (please print): ___________________________ DOB: _____________

In order for us to best serve you, it is necessary for us to request, from your health care providers, additional medical information. It is important to our evaluations, diagnosis and subsequent treatment plan, that we gain access to such information as: diagnostic testing reports (MRI's, CT Scans, X-rays, etc), surgical reports and office visit reports. Please authorize us to make these requests by signing this form.

I authorize medical/clinical information on the above named patient to be sent to Mountain Center Physical Therapy, as this information relates to the diagnosis for which I am seeking treatment.

- I understand that the information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.
- I understand I may revoke this authorization at any time by requesting such of the above referenced facility in writing unless action has already been taken in reliance upon it, or during a contestability period under applicable law.

(This authorization expires six months from the date signed unless informed otherwise.)

INFORMATION REQUESTED:____

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_________________________________ _________________________

Signature of Patient or Legal Representative Date

_________________________________ _________________________

Printed name of Patient or Legal Representative Relationship to Patient

37 Main Street ~ P.O. Box 1828 ~ Conway, NH 03818 ~ 603-447-2533 ~ Fax: 603-447-2544