In Motion Therapy™

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my health information as described below. I understand the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.

Patient Name: _____ DOB: _____ MR #: _____

Organization Providing the PHI	Organization receiving the PHI
In Motion Therapy	
2701 W. Superior St. Ste. 112	
Duluth, MN 55806	
Ph: (218) 727-1180 fx: (844)856-3737	

Reason for Disclosure: Specific description of information (including date(s)/purpose):

_____

_____

(**Note**: *"at the request of the individual" is a sufficient description of the purpose when the patient initiates the authorization and elects not to provide a statement of the purpose*.)

Information Disclosed: Please check the boxes that apply

□ Copy of clinic notes
□ Copy of discharge summary
□ Copy of all records
□ Other_____

Must be completed for all authorizations:

I understand that I have the right to refuse to sign this form and that my refusal will not result in the physician conditioning the provision of healthcare with two exceptions:

1. Refusal to sign this authorization, if it is for disclosure of information created for research that includes treatment, may result in the physician declining to provide the research related treatment.
2. Refusal to sign this authorization, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to a third party.

Patient initials: _____

I understand that this authorization will expire on the following date___/___/_____(MM/DD/YR).

I understand that I may revoke this authorization at any time by notifying the healthcare provider in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

_____ _____

Signature of Patient/Patient's Representative Printed Name of Patient/Patient's Representative

_____

Date Telephone Number