FOOTHILLS
SPORTS MEDICINE
PHYSICAL THERAPY

MEDICAL RECORDS RELEASE

Patient Name:_____ DOB:_____ Acct #:_____

Phone #:_____ Email Address:_____

☐ All Medical Records. I,_____, give consent to Foothills Sports Medicine

Physical Therapy to release my medical records from _____through _____. (☐ Check for ALL dates)
(mm-yyyy) (mm-yyyy)

This authorization shall be considered invalid after six (6) months from the date of signing. The undersigned may revoke this authorization at any time by providing written notice of revocation; however, the undersigned may not revoke authorization retroactively for information already released.

I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan.

Records should be (select one):

☐ Emailed to* Patient Name/Provider:_____

Email Address:_____

*By selecting this option, I assume the risk involved in transmitting my Personal Health Information (PHI) via email.

☐ Faxed to Patient Name/Provider:_____

Fax #:_____ Phone #:_____

Attn:_____

☐ Mailed to Patient Name/Provider:_____

Address:_____

City, State, Zip:_____

Patient or Legal Representative Signature:_____ Date:_____

Relationship, if not Patient:_____

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