

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

**Patient name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Organization Providing the Information:** \_\_\_\_\_

**Organization Receiving the Information:** Parry Physical Therapy Group  
361 S 11<sup>th</sup> St, Ste 2  
Quakertown, PA 18951  
P: 215.538.1999  
F: 215.538.9004

**Description of Information requested/disclosed:**

DIAGNOSTIC TESTING REPORTS:

- PLAIN FILM X-RAY
- MRI
- CT SCAN
- BONE SCAN

DATE OF TESTING \_\_\_\_\_

- OPERATIVE REPORT

DATE OF SURGERY \_\_\_\_\_

**Purpose of Disclosure:** For physical therapy treatments

I understand that I may revoke this authorization at any time by Notifying Parry Physical Therapy Group in writing, but if I do, it will not have any effect on any actions Parry Physical Therapy Group took before they received the revocation.

Initials: \_\_\_\_\_

Signature of patient or representative

\_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

You may refuse to sign this authorization.  
We cannot condition treatment on your signing this authorization.