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
723 Route 113, #6
Souderton, PA 18964
P: 215.538.1999
F: 267.382.0088

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. This authorization expires one year from the signature date.
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.