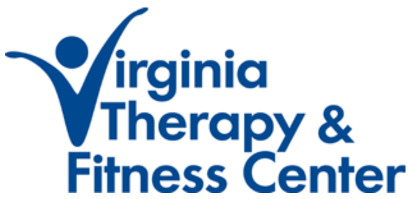

Jaison Alderman, PT, DPT
Jason Arnett, ATC
Richard A. Banton, PT, DPT, ATC
Brent Conover, PT,DPT
Kevin Dandy, MPT
E. Laurence Grine, MSPT, ATC
Brandon McWilliams, PT, DPT
Kur Sohn, PT, DPT
Jessica Stepien, PT, DPT

Request for Medical Records Release

Patient Info

Last Name, First Name ______________________ Date of Birth ______________________

Address ______________________ SSN (last 4 digits) XXX-XX-______

______________________ Phone 1 ______________________

City, State, Zip Phone 2

I authorize **Virginia Therapy & Fitness Center to** ***release medical records***

Name of Facility/Person ______________________ Relationship to Patient ______________________

Address ______________________ Phone ______________________

City, State, Zip Fax

Method of Delivery: ☐ In office pick up ☐ Mail to address above ☐ Fax to above number

Information to be Disclosed

☐ All VTFC Records ☐ Partial Records Dates: __/___/______ to ___/___/_______

☐ Treatment Notes Only ☐ Billing/Account Information Only ☐ Patient Registration/History Only ☐ Physical Therapy Rx(s) Only

☐ Other: ____ (please specify)

Purpose of Disclosure

☐ Auto/Legal Settlement or Attorney ☐ Personal Records ☐ Physician Request

☐ HRA/FSA or Insurance Submission ☐ Disability Determination ☐ Other: ___________________________

I hereby authorize disclosure of the health information for the above named patient. This information may include psychiatric, substance abuse, and HIV/AIDS information. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal regulations. I may receive a copy of this authorization for my records. Unless otherwise specified, this authorization expires 2 years from date signed.

Patient/Guardian Signature ____ **Date**______________________

Patient Name ____ **Relationship to Patient**____________________