ELEVATE
PHYSICAL THERAPY
FITNESS AND PERFORMANCE

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient Information
Patient Name: _____ Date of Birth: _____
Phone Number: _____ Email: _____
Address: _____

Purpose of Authorization *(Select all that apply)*
☐ Continuing Care ☐ Insurance ☐ Legal ☐ Personal Use
☐ Other: _____

I authorize my health information to be: **Sent to** _____ **or** **Requested from** _____
Provider/Facility/Individual Name: _____
Phone: _____ Fax: _____
Address: _____

Information to be released:
☐ Complete Medical Record ☐ Initial Evaluation ☐ Progress Notes ☐ Plan of Care
☐ Discharge Summary ☐ Billing Records ☐ Imaging Reports ☐ Other: _____

Date(s) of Service: _____

Delivery Method for Elevate Records:
☐ Printed - Mail ☐ USB Drive - Mail ☐ Secure Fax
☐ Printed - Patient Pick-Up @ Elevate ☐ USB Drive - Patient Pick-Up @ Elevate

Acknowledgment and Authorization
I understand that:

- Release of certain information, including but not limited to mental health records, substance use disorder treatment records, HIV/AIDS-related information, and genetic testing information, may require additional specific authorization under State and Federal law.
- My treatment, payment, enrollment, or eligibility for benefits is not conditioned upon signing this authorization.
- This authorization is voluntary and I have the right to refuse to sign this authorization.
- I may revoke this authorization at any time by submitting a written revocation to Elevate Physical Therapy Fitness and Performance, Attn: Medical Records Department, at the address listed above, except to the extent that action has already been taken in reliance on this authorization.
- This authorization will expire one (1) year from the date signed unless otherwise specified here: _____, or unless revoked earlier in writing.
- Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.
- A reasonable, cost-based fee for copies of records may apply in accordance with applicable Oregon and federal law. Postage fees may apply if records are mailed. Payment is due prior to release of records. Records will be provided within 30 days of receipt of a valid request, as permitted by law. If an extension is necessary, I will be notified in writing.
- I am entitled to receive a copy of this signed authorization.
- I understand that this authorization applies only to the information described in this form.

Patient Signature: _____
Printed Name: _____ Date: _____

If signed by personal representative:
Name of Representative: _____ Relationship to Patient: _____
Signature: _____ Date: _____

2316 S. 6th Street, Suite A, Klamath Falls, OR 97601
Ph: 541-887-2030 | Fx: 541-887-2070
info@elevateptfp.com | www.elevateptfp.com