FINE TUNED
PHYSICAL THERAPY

HIPAA RELEASE AUTHORIZATION FORM

Patient's Full Name _____ Patient's Date of Birth _____

Address _____ Apt/Unit Number _____

City, State Zip Code _____ Patient's Telephone Number _____

I hereby authorize Fine Tuned Physical Therapy PLLC to release protected healthcare information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   Fine Tuned Physical Therapy PLLC

2. The following person (or class of persons) may receive disclosure of protected healthcare information about me:

   Name: _____ Name: _____

   Relationship: _____ Relationship: _____

   Phone: _____ Phone: _____

   Email: _____ Email: _____

3. The specific information that should be disclosed is (please give dates of service if possible):

   _____

4. 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 privacy regulations.

5. I may revoke this authorization by notifying Fine Tuned Physical Therapy PLLC in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

6. This authorization doesn't have an expiration date unless specified: _____

   Initial Here

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

_____ _____

Patient's Signature Date

_____ _____ _____

Signature of Parent/Guardian or Personal Representative of Patient's Estate

Date of Guardian's/Personal Representative's Signature

Description of Authority to Act for the Individual

A copy of this completed, signed and dated form must be given to the Individual or other signatory if requested.