



# MAJERUS & CO. PHYSICAL THERAPY AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

\_\_\_\_\_  
(PRINT name of patient)

Date of Birth: \_\_\_\_\_

Information to be released from:

\_\_\_\_\_  
(Name of designated Facility or Provider)

Information to be released to:

\_\_\_\_\_  
(Name of Patient, designated Person, Facility of Provider)

\_\_\_\_\_  
(Street Address)

\_\_\_\_\_  
(Street Address, if applicable)

\_\_\_\_\_  
(City, State and Zip Code)

\_\_\_\_\_  
(City, State and Zip Code, if applicable)

\_\_\_\_\_  
(Phone and/or Fax Number, if applicable)

\_\_\_\_\_  
(Phone and/or Fax Number, if applicable)

Information to be released:

By Initialing in the spaces below, I specifically authorize the disclosure of the following health information and records.

\_\_\_\_\_ Chart Records developed between \_\_\_\_\_ to \_\_\_\_\_ (Insert start & end dates)

\_\_\_\_\_ Other: \_\_\_\_\_ (Specify information requested)

\_\_\_\_\_ Billing record (Note to Patient/Legal Representative: This will be mailed to you as we do not have billing records on site)

Purpose for which disclosure is being made:

Personal     Medical     Insurance     Legal     Other: \_\_\_\_\_  
(specify reason)

Patient Authorization:

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked, this authorization will expire within 90 days. To revoke this authorization, please send a written statement to Joint Ventures Therapeutics, PC, d/b/a Majerus & Co. Physical Therapy, 16219 SE 12<sup>th</sup> St, #100, Vancouver, WA 98683

SIGNATURE: \_\_\_\_\_  
(Patient or Personal/Legal Representative (Next-of-Kin or Legal Guardian to Sign Only If Patient is a Minor, Legally Incompetent or Deceased))

PRINT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Relationship to Patient of Personal/Legal Representative Signing: \_\_\_\_\_

For Office Use only: [    ] Patient's or Legal Representative's Personal Identification Verified