



BARROWS

TRAINING AND EDUCATION
PHYSICAL THERAPY

Where excellence and experience make a difference in your care.

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

(Please Print)

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Section 56, et, seq., California Civil Code.

AUTHORIZATION

I hereby authorize: _____
Name of health care provider

to furnish Barrows Physical Therapy medical records and information pertaining to medical history or physical condition, services rendered, or treatment for

Name of Patient

Date of Birth

This authorization is limited to the following records and type of information: All medical records.

USES: The requester may use the medical records and type of information authorized only for the following purposes: Medical evaluation and care.

DURATION: This authorization shall become effective immediately and shall remain in effect until my notifying you to the contrary.

RESTRICTIONS: I understand that requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or disclosure is specifically required or permitted by law.

ADDITIONAL COPY: I further understand that I have a right to receive a copy of this authorization upon my request.

Signature

Date

Type of Information Requesting:

<input type="checkbox"/> History / Physical	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Operative Report	<input type="checkbox"/> X-Ray	<input type="checkbox"/> CT Scan	<input type="checkbox"/> MRI
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Date of service: _____