



Physical Therapy  
Sports Medicine  
Fitness

## AUTHORIZATION FOR DISCLOSURE OF HEALTH RECORDS

I, the undersigned patient/guardian, hereby authorize ProActive Fitness to release information from the medical records of:

Patient: \_\_\_\_\_

Birthdate: \_\_\_\_\_

SSN: \_\_\_\_\_

- Purpose Of Request:
- |   |  |
|---|--|
| <input type="checkbox"/> Second Opinion         | <input type="checkbox"/> Continuation Of My Treatment            |
| <input type="checkbox"/> For My Attorney        | <input type="checkbox"/> Transfer Of My Care To Another Provider |
| <input type="checkbox"/> For Completion Of Form | <input type="checkbox"/> Other _____                             |

I authorize the release of the following protected health information:

\_\_\_\_\_ All Medical Records / All Protected Health Information

\_\_\_\_\_ Medical Records During The Period Of: \_\_\_\_\_ To \_\_\_\_\_

Party To Whom Records Should Be Released:

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Purpose For Request: \_\_\_\_\_

I understand that this authorization for release of information is in force:

Until revoked by me in writing or

Until \_\_\_\_\_ (Date)

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name Of Patient/Guardian