thrive physical therapy

Thrive Physical Therapy 9518 Roosevelt Way NE, Seattle, WA 98115
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Authorization to release medical records and information

Patient Name: _____ Other name:_____
Date or birth:_____
Current Address :_____
Daytime phone:_____ Alternate phone: _____

Reason for Records:

- ☐ Personal
- ☐ Medical Care
- ☐ Benefits
- ☐ Attorney/Litigation
- ☐ Workman's Comp

I authorize information release from:

_____
Name of Facility

_____
Name of Physician

_____
Address, city, state, zip

Please send my records to:

_____
Facility to receive information

_____
Title (Physician, Physical therapist etc)

_____
Address, city, state, zip

Type of information to be released:

- ☐ Complete Medical Records
- ☐ Evaluation and Discharge Reports only
- ☐ All Chart notes
- ☐ Billing Records
- ☐ X-Ray Reports
- ☐ MRI Reports
- ☐ Surgical Reports
- ☐ Other: _____

I understand that I am authorizing the release of my medical records to and from the facilities and people above and I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon this authorization. I understand I have the right to refuse to sign this authorization as well.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Patient Name or Patient's Legal Representative Relationship to Patient