2129 Providence Ave., Chester, PA 19013
Phone: 610.499.4585
Fax: 610.499.4594

Authorization to Release Healthcare Information

Patient Name: ______________________ Date of Birth: ______________________

Former Name: ______________________ Phone Number: ______________________

I authorize Chester Community Physical Therapy Clinic to release all of my healthcare information to my physician as listed below:

Name: ____
Address: ____
City: ______________________ State: __________ Zip: __________

This authorization also applies to the following individuals:

Name: ____
Relationship: ____
Address: ____
City: ______________________ State: __________ Zip: __________

Name: ____
Relationship: ____
Address: ____
City: ______________________ State: __________ Zip: __________

By signing this form, you are authorizing the use or disclosure of your protected health information as described above. This information may be re-disclosed if the recipient is not required by law to protect the privacy of the information. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, otherwise restrict my ability to authorize the use or disclosure of this protected health information.

Patient Signature: ______________________ Date: ______________
Patient Name: ____

THIS AUTHORIZATION EXPIRES UPON DISCHARGE FROM SERVICES