Big Stone Therapies, Inc. Authorization for Release of Information

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Maiden/Previous Names/Nickname: _____

Facility/ Provider Releasing Information

Who is releasing the information?

_____

Facility/Provider Name

_____

Facility Address

Disclose Information To

Where is the information to be sent?

Facility/Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Information to be disclosed

I hereby authorize the above Provider/Location to release any/all medical record information concerning my treatment for the period of (specific dates or years of treatment)

_____ to _____

Please specify which information is to be disclosed:

_____ Physical Therapy Records

_____ Speech Therapy Records

_____ Radiology Reports

_____ Occupational Therapy Records

_____ Radiology Images

_____ Other: _____

Purpose of Disclosure

_____ Continuing Care

_____ Transfer of Care

_____ Disability Claim

_____ Other: _____

Form of Delivery

_____ Verbal Discussion

_____ Fax

_____ Mail

_____ Pick up by patient or authorized designee

_____ Encrypted Email/Electronically

_____ Other: _____

Expiration Date

This authorization will expire one year from the date of signature or on: _____

Revocation

I understand that I may revoke this consent at any time by sending a written notice to the facility above. However, the revocation is not valid if information has already been released per this authorization.

Authorization

I hereby authorize the above facility/provider to disclose medical information concerning the above named patient to the party in the section entitled "Disclose Information To". I understand that once the information is disclosed, it may be subject to re-disclosure by the recipient. I understand that this authorization is voluntary and that I may refuse to sign this authorization, however, it may result in inadequate patient care. A photocopy/fax of this authorization will be treated in the same manner as the original.

_____ _____

Signature (Patient or Legal Guardian) Date

_____

Relationship (if not patient)