Osprey Physical Therapy & Sports Medicine

Soaring Together In Your Health and Wellness

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS & PATIENT INFORMATION

I have read and fully understand Osprey Physical Therapy and Sports Medicine Notice of Patient Information Practices.

I authorize Osprey Physical Therapy and Sports Medicine to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to therapy treatment or examination rendered to me.

I understand that this medical information may be used or disclosed for the following purposes: diagnostic, carrying out treatment, evaluating the quality of services provided, when deemed necessary to ensure the best medical care on my behalf, obtaining payment, insurance, legal, and any administrative operations related to treatment or payment.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient and may no longer be protected by federal confidentiality law (HIPAA); however, Oregon law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. Please indicate below any information that you do not wish disclosed or any entities that you do not permit to receive information:
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I also understand that Osprey Physical Therapy and Sports Medicine will consider requests for restriction on a case-by-case basis but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Osprey Physical Therapy and Sports Medicine's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent at any time. If I decide to restrict or revoke this authorization for my health information, I must notify the practice in writing, signed by me or on my behalf. I hereby release Osprey Physical Therapy and Sports Medicine and its employees from any liability from the release of this information.

Patient Signature: _____________________________________ Date: ___________________

Print Patient Name: ____________________________________

Responsible Party (if Patient is a minor): ____

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