QUALITY CARE PHYSICAL THERAPY

Sports Rehabilitation
Work Injuries
Pre & Post Surgery Rehab
Orthopedics
Biomechanical Analysis
Spine Rehabilitation
Motor Vehicle Accidents
Dance Rehabilitation

Medical Records Release Form

Name: _____ Date of Birth: _____

Name at time of treatment if different from above: _____

Phone Number: _____

Address: _____ City: _____ State: ____ Zip Code: _____

Type of Medical information requested: _____

Health information for following treatment or condition (body part): _____

Health information relating only for the following date (s): _____

Reason for Request:

Personal: ____ Legal: ____ Transfer of Care: _____ Other: _____

I understand that if the person or entity receiving the information is not a heath care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations.

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORD UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTHCARE FACILITY OR UNLESS HIPPA REGULATIONS OR WASHINGTON LAW PROHOBITS OR LIMITS FEES OTHERWISE ALLOWED

Personal records will be charge as per RCW 70.02.010: Paper Copy: $1.17 per first 30 pages, $.88 for each additional page. CD: $28 clerical fee (includes cost of CD). USB (must be presented in original package): $26 clerical fee

Unless revoked earlier or otherwise indicated, this authorization will expire 60 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

You must provide name, address and fax number of provider/health care facility or the name and address of any other person you wish to have your information released to:

_____

_____

I authorize Quality Care Physical Therapy, Inc to release my medical records to the above listed provider or person. You have the right to revoke this authorization at any time, provided you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this authorization.

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18404 102nd Ave NE, Suite A, Bothell, WA 98011 Phone 425.486.6079 Fax 425.486.7077
Info@QualityCarePT.com www.QualityCarePT.com

Printed Name of Patient/Legal Guardian

Signature of Patient/Legal Guardian Date

Relationship to patient, if other than patient _____

(You may be required to provide legal documentation as proof of power of attorney or guardianship if not the patient)

By your signature above, you acknowledge that you hereby agree to and authorize the release of patient health information to the named person or organization.

Internal

Type of record requested: _____

Drivers License Verified: ____

Name: _____ *Date:*_____