FX PHYSICAL THERAPY
MEDICAL RECORDS DEPARTMENT
11270 Pepper Rd ■ Hunt Valley, MD 21031
410-708-4763 ■

RELEASE OF MEDICAL RECORD AUTHORIZATION FORM

Note to Recipient of Records: The patient's medical record is privileged information which is protected by various State and Federal laws. Such information may not be further disclosed to other persons without a separate written authorization from the patient.

PATIENT INFORMATION:		**RELEASE FROM:**	
Name:	_____	Name:	_____
Address:	_____	Address:	_____
	_____		_____
DOB:	_____		_____
Phone #:	_____		_____

Authorize Felice Physical Therapy doing business as FX Physical Therapy to release to the party listed below the following information from my medical records:

(Check and/or circle appropriate items)

- □ Complete record
- □ Abstract (face sheet, history and physical, discharge summary, consult)
- □ Diagnoses
- □ Physical Therapy notes
- □ Progress notes
- □ Other _____

My Medical record may be inspected by and/or copies may be released to:

_____
(Name of Person) (Name of Affiliated Organization or Relation)

_____
(Street Address) (City) (State) (Zip Code)

for the purpose of: _____

_____
(Patient's Signature) (Date)

If the patient is a minor, subject to a guardianship or is deceased, I have signed my name below on behalf of the patient and myself:

_____ _____
(Patients', Legal Guardian's or Agent's Signature) (Date)

I witnessed the signature on this form: Name of Witness: (Please Print) _____

_____
(Witness's Signature) (Date)

_____
(Patients', Legal Guardian's or Agent's Signature) (Date)