ADVANCED BODY SOLUTIONS, Inc

Medical Release Form

Patient Name: _____ Patient Birth Date: _____/_____/_____

Patient Address: _____

Release Records From (Provider's Office):

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Release Records To (Records to be sent to):

Name: _____

Address: _____

Phone Number: _____ Fax Number: _____

Medical Records to be released (Please initial request):

___ Specific time period: _____

___ Most recent office notes

___ Entire medical record

___ Billing Statement / Financial Summary

___ Other: _____

Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to Advanced Body Solutions, Inc. Unless revoked earlier, this authorization will expire one year from the date signed. Date Expires: _____

I also understand that, if the person or entity receiving this information is not a healthcare provider or health plan covered by Federal Privacy Regulations, the information described above may be re-disclosed and no longer protected by the Health Insurance Portability and Accountability Act of 1996. However, the recipient may be prohibited from disclosing my health information under other applicable state or federal laws and regulations. This facility, its employees and therapists are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Patient's Signature: _____ Date: _____

For administrative use only: Date Completed: _____ Faxed: ___ Mailed: ___ Picked Up: ___

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