FREE BODY SF, LLC

AUTHORIZATION TO RELEASE X-RAYS AND MEDICAL RECORDS

TO:____

(NAME OF HEALTHCARE PROVIDER, HOSPITAL, CLINIC, ETC.)

ADDRESS:____

I, _______________________________, DOB:____________ request the following information:

_____ X-RAYS/RADIOGRAPHS

_____ MEDICAL RECORDS

_____ STATUS REPORTS

_____ TREATMENTS

_____ OTHER

TO BE RELEASED TO:

FREE BODY SF PHYSICAL THERAPY & REHAB

40 PAGE STREET

SAN FRANCISCO, CA 94102

415-602-0190

FOR THE PURPOSE OF:____

(REVIEW, EVALUATION, AND/OR INSURANCE PROCESSING)

I UNDERSTAND THAT I HAVE THE RIGHT TO RECEIVE A COPY OF THIS AUTHORIZATION UPON MY REQUEST.

NOTICE OF PRIVACY PRACTICES

I HAVE REVIEWED THE ACT OF THE HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA) AND ACKNOWLEDGE THE FEDERAL RULES TO PROTECT THE RIGHTS OF PERSONAL HEALTH INFORMATION.

PATIENT NAME:____

PATIENT SIGNATURE:____________________________________ DATE:________________