Restorative THERAPIES
Your advocate for life.

AUTHORIZATION TO RELEASE OR OBTAIN PHI

PATIENT INFORMATION

Name: _____ **Date of Birth:** _____
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Phone #: _____ **Email:** _____

INFORMATION TO BE RELEASED FROM

☐ **Restorative Therapies, Inc.** 8098 Sandpiper Circle, Suite M, Nottingham, MD 21236
☐ **Individual/Organization:** _____

INFORMATION TO BE SENT TO

☐ **Restorative Therapies, Inc.** 8098 Sandpiper Circle, Suite M, Nottingham, MD 21236; FAX: 443-835-4947
☐ **Individual/Organization:** _____

INFORMATION TO BE DISCLOSED

Type: ☐ Outpatient Records ☐ Inpatient Records
☐ History & Physical Exams ☐ Consult Reports (including Neurological Report/Consult)
☐ Office/Progress Notes ☐ Physical and Occupational Therapy Evaluations
☐ Physician Orders (e.g. Prescription, Letter of Medical Necessity, Referral, etc.)
☐ Other: _____

Dates: ☐ For all dates of service ☐ For date(s) of service from _____ to _____

Sensitive Information: ☐ DO NOT include sensitive information ☐ Include sensitive information below:
☐ information related to sexually transmitted disease, human immunodeficiency virus (HIV), and/or acquired immunodeficiency syndrome (AIDS)
☐ behavioral and/or mental health records
☐ information related to alcohol and/or drug abuse treatment

PURPOSE OF DISCLOSURE

☐ Healthcare/treatment ☐ Payment/insurance purposes ☐ At my request
☐ Other: _____

AUTHORIZATION

This authorization is valid until: ☐ One year from the date of the signature below
☐ A specific date or event: _____

By signing below, I understand that:

- This authorization is voluntary and will not impact my treatment.
- I may revoke this authorization at any time by submitting a request in writing.
- Protected health information (PHI) used or disclosed per this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations.

Signature of Patient or Representative*: _____ **Date:** _____

Name of Representative: _____ Relationship to Patient: _____

**** If not signed by the patient or parent of a minor child, authorizing documentation is required.***

(e.g. Power of Attorney or Legal Guardianship)