

PATIENT'S REQUEST TO RELEASE MEDICAL RECORDS

I hereby authorize EmpowerMe Wellness, LLC to release my protected health information (PHI) to me, my responsible party, or the entity identified below.

Patient Name: _____ Patient Date of Birth: _____

Community: _____

Patient's Responsible Party: _____

Patient/Responsible Party Phone #: _____

Send records to (person to entity): _____ via:

☐ Fax (enter fax number): _____

☐ Mail (enter address): _____

☐ Email (enter email): _____

Service lines to include:

☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy

☐ Nurse Practitioner Services

☐ Therapy Services

☐ Therapy Order ☐ Evaluation ☐ Progress Notes ☐ Discharge Summary

☐ Laboratory Services

☐ All Medical Records Across All Service Lines

Records to include:

☐ Clinical Only ☐ Billing Only ☐ Clinical and Billing ☐ All Medical Records for All Service Providers

☐ Other: _____

Include records from date of service _____ to _____

The information to be used or disclosed pursuant to this authorization may include information relating to:
(1) AIDS or HIV infection; (2) treatment of drug or alcohol use; or (3) mental or behavioral health or psychiatric care; (4) sexually transmitted disease; or (5) genetic testing.

I have read the above information and authorize disclosure of the identified information to the person/ organization and for the purpose described herein. I understand that, by signing this document, I release and discharge the disclosing entity from any liability and will hold it harmless for any release made pursuant to the authorization.

Patient/Responsible Party Signature: _____

Responsible Party Relation to Patient: _____

Date Signed: _____ Authorization Expires: _____

(Up to one year if not otherwise specified)