TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

14815 W. Bell Road. Suite 110 Surprise, AZ 85374
Phone 623-777-1870 Fax 623-777-1403

Authorization to Release Medical Records

Patient Name_____ DOB_____
Nombre del paciente Fecha de Nacimiento

This authorization releases True Care Physical Therapy and Rehabilitation, PLLC and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from any person, or distress of any type caused by me or others. True Care Physical Therapy and Rehabilitation, PLLC will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

This Authorizes: True Care Physical Therapy and Rehabilitation, PLLC
14815 W. Bell Road. Suite 110 Surprise, AZ 85374
Phone: 623-777-1870 Fax: 623-777-1403

To Release Information to: _____
Physician's Office/ Day Care/ Parent Name)
Oficina del Medico/Guarderia /Nombre de los padres/ Guardian legal

_____
(Address/ City/ State/ Zip)
Domicilio/Ciudad/Estado/Codigo Postal

_____
Phone Number Fax Number (please note will not call prior to faxing)
Numero de telefono Numero de Fax

For the Following Purpose: (check one)
Por el siguente proposito: (marque uno)

____New Primary Care Physician ____Personal Records for personal use ONLY*
Nuevo Doctor Para uso personal SOLAMENTE
____Cosultation with Specialist ____ Other (Specify)_____
Consulta con el especialista Otros (especifique)

Type of records requested: (check one)
Tipo de informacion requerida (marque una)

_____ All Medical Records _____ The following described records only (specify types and dates)
Solo los siguentes expedients medicos (especifique tipo y fechas)

_____

____DO NOT RELEASE THESE RECORDS (specify types and dates) _____
No libere este expediente medico (especifique tipo y fechas)

_____

FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE-RELATED INFORMATION (AS DEFINED IN 42 CFR SECTION 2.1 ET SEQ.), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS / TREATMENT INFORMATION. I understand this authorization is valid for up to 90-days unless I chose to revoke it in writing prior to the expiration date. I understand and agree that I may be responsible for ***A fee of $25.00 will be charged for records released to patient for personal use only. This charge is waived if records are forwarded to another physician's or Attorney's office.**

IF PATIENT IS 18 YRS OR OLDER, THEY MUST SIGN THIS RELEASE FORM

_____ _____
Signature and Name of Patient or Legal Guardian Date
Firma de los padres o Guardian legal Fecha de hoy

_____
Relationship to Patient
Parentesco con el paciente

_____
Office use only: Provider Approval _____Record prepared and transmitted by:_____Date:_____
Records released ☐to pt in office ☐via mail ☐ faxed to_____ ☐ Fee Collected