

APEX HAND THERAPY, LLC

Hand, Wrist, Elbow & Shoulder Rehab

Tel: (703) 242-4263, Fax: (703) 242-6368

RELEASE OF MEDICAL RECORDS

I - I authorize Apex Hand Therapy, LLC to disclose/receive the following information from the health records of:

PATIENT INFORMATION	LAST NAME	FIRST NAME	MIDDLE NAME
	SOCIAL SECURITY NUMBER (SSN)	DATE OF BIRTH	PHONE NUMBER
			() -
	HOME – STREET NAME & NUMBER	CITY, STATE & ZIP CODE	

II - Check all that Apply:

INFORMATION TO BE DISCLOSED	COMPLETE HEALTH RECORD	HISTORY & PHYSICAL EXAM	X-RAY REPORTS
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	OPERATIVE REPORTS	TREATMENT REPORTS	DISCHARGE SUMMAY
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LABORATORY REPORTS	OTHER (SPECIFY)	
	<input type="checkbox"/>	<input type="checkbox"/>	
	I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION RELATING TO:		
AIDS OR HIV INFORMATION	BEHAVIORAL HEALTH CARE	ALCOHOL & DRUG ABUSE TREATMENT	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

III. This Information is to be disclosed to:

RECEPIENT INFORMATION	LAST NAME	FIRST NAME	MIDDLE NAME	
	TITLE	PHONE NUMBER	FAX NUMBER	
		() -	() -	
	STREET NAME & NUMBER	CITY, STATE & ZIP CODE		
	INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:			

IV. I understand that this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance to it. Unless otherwise revoked, it will expire on the following date, event, or condition: _____

V. Apex Hand Therapy, LLC / _____, its employees, officers, & therapists are released from any legal responsibility or liability for disclosure of the above information to the extent indicated & authorized heir in.

PATIENT OR LEGAL GUARDIAN NAME (PRINT): _____

PATIENT OR LEGAL GUARDIAN SIGNATURE

DATE