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
☐	☐		☐
OPERATIVE REPORTS	TREATMENT REPORTS		DISCHARGE SUMMAY
☐	☐		☐
LABORATORY REPORTS	OTHER (SPECIFY)		
☐	☐		
I UNDERSTAND THAT THIS MAY INCLUDE INFORMATION RELATING TO:			
AIDS OR HIV INFORMATION	BEHAVIORAL HEALTH CARE		ALCOHOL & DRUG ABUSE TREATMENT
☐	☐		☐

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**