Authorization for Release of Information

the JACKSONCLINICS physical therapy

PATIENT NAME: _____
LAST FIRST MI MAIDEN OR OTHER NAME

DATE OF BIRTH: ____-____-____ PATIENT ACCOUNT #:_____
MO DY YR

DAY PHONE:_____EVENING PHONE_____

I HEREBY AUTHORIZE THE JACKSON CLINICS, LP TO RELEASE INFORMATION FROM MY MEDICAL RECORD AS INDICATED BELOW TO:

NAME: _____

ADDRESS: _____CITY:_____ STATE_____ZIP_____

PHONE: _____FAX:_____EMAIL:_____

PREFERRED DELIVERY METHOD: ☐ Fax ☐ Postal Mail ☐ Secure Email

Are these records being sent to a facility for ongoing care or follow up treatment? ☐ Yes ☐ No

INFORMATION TO BE RELEASED:

	DATES
☐ Treatment Notes	_____
☐ Itemized Statement	_____
☐ Other _____	_____
_____	_____

PURPOSE OF DISCLOSURE: ☐ Changing physicians ☐ Consultation/second opinion ☐ Continuing care
☐ Legal ☐ School ☐ Insurance ☐ Workers compensation
☐Other(please specify)_____

1. I understand that this authorization will expire after 1 year unless otherwise specified. Specify Other: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I am being requested to release this information by The Jackson Clinics, LP for the purpose of;

   _____

   a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
   b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
   c. I have been informed that The Jackson Clinics, LP ☐ will/☐ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
5. I understand that in compliance with Virginia statute, I will pay the fee of $10 in addition to $.50/per page (up to 50 pages) and $.25/per page thereafter. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment. ***PREPAYMENT IS REQUIRED PRIOR TO THE RELEASE OF MEDICAL RECORDS**

_____ _____ OR _____ _____
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT