

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete all sections legibly. Incomplete forms may result in delay or denial of this request.

1. PATIENT INFORMATION	PATIENT NAME: _____		
	DOB: / /	PREVIOUS NAME(S): _____	
2. RELEASE MY RECORDS FROM	FACILITY NAME: _____		
	DR. NAME: _____		
3. SEND MY RECORDS TO	NAME: _____		ATTN TO: _____
	ADDRESS: _____		
	CITY: _____	STATE: _____	ZIP: _____
	PHONE: _____		FAX (For Continuing Care ONLY): _____
	Email: _____ (Only if you want records sent via encrypted email)		
4. TYPES OF RECORDS	DATE(S) OF SERVICE: _____		
	☐ All Health Records (not including billing or imaging) ☐ Nutritional Counseling Notes ☐ Billing Records ☐ Physical Therapy Notes ☐ Other _____		
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____		
	"Verbal disclosure" authorizes Infinite Health Collaborative to discuss my care with the person(s) indicated in this section: _____		
6. REASON FOR REQUEST	☐ Personal Use ☐ Disability ☐ Insurance ☐ Legal ☐ Workers Compensation ☐ Continuing Care		
7. RETURN COMPLETED FORMS TO:	MAIL TO: OSI Physical Therapy 433 East Mendota Rd West St. Paul, MN 55118		FAX TO: 651-770-1180 EMAIL TO: recordsrelease@osipt.com DROP OFF: Any OSI PT Location
	* Records will be mailed to the person(s) identified in section 3. Please allow up to 2 weeks for processing.		
8. I UNDERSTAND THAT BY SIGNING THE BELOW:	- I may revoke this authorization at any time by notifying the facility identified above in writing. - By authorizing the release of my protected health information, the health information is no longer protected and has the potential to be re-disclosed. - There may be a fee for release of this information and I may be responsible for that fee. - I am authorizing the release of my personal protected health information from any i-Health facility unless otherwise specified above - Treatment will not be denied to me if I do not sign this form. - This authorization will expire one year from the date I sign on this form unless specified: _____ - i-Health is a multispecialty practice including, and without limitation, the clinic above. Your i-Health record will be released, unless you otherwise specify in writing		
	SIGNATURE: _____ DATE: _____ PRINT NAME: _____ *If this form is signed by someone other than the patient, legal documentation showing guardianship or authorization must be on file or presented with this form.		