Internal Use Only | Account #_____

Pickup Instructions_____

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 ☐ Insurance ☐ Workers Compensation ☐ Disability ☐ Legal ☐ Continuing Care	
7. RETURN COMPLETED FORMS TO:	**MAIL TO:** OSI Physical Therapy 433 East Mendota Rd West St. Paul, MN 55118	**FAX TO:** 651-413-2204 **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.

Electronic Typed Signatures cannot be accepted