iHealth
Infinite Health Collaborative

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: OSI Physical Therapy	
	DR. NAME:	
3. SEND MY RECORDS TO	NAME: iHealth	ATTN TO: Therapy Department
	ADDRESS:	
	CITY:	STATE: ZIP:
	PHONE:	FAX (For Continuing Care ONLY): 651 - 356 - 6044
	EMAIL: (Only if you want records sent via encrypted email)	
4. TYPES OF RECORDS	BODY PART:	
	DATE(S) OF SERVICE:	
	☑ Office Notes ☐ Radiology Reports ☐ Lab Reports	☐ Hospital Reports ☑ Therapy (Occupational or Physical) ☐ Dietary Records
5. VERBAL DISCLOSURE	For verbal disclosure, check here: _____	
	"Verbal disclosure" authorizes i-Health 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	
	Do you need imaging studies? ☐ Yes ☑ No (All images will be sent via email)	
7. RETURN COMPLETED FORMS TO:	**MAIL TO:**	
	* 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 to and from the entities I've indicted 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.

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.