Elite Physical Therapy
& WELLNESS CENTER
Restoring optimal health through specialized care.

manual therapy | sports medicine | massage therapy | pilates

Medical and/or Financial Record Request Form

1. I, hereby request that ELITE PHYSICAL THERAPY AND WELLNESS CENTER disclose the records identified in this request to the individuals/entities identified herein.

2. The purpose of this request for medical records is: (Check all that apply) o I am moving and need to transfer my records to another health care provider. o I am consulting with another health care professional. o Other:
_____

3. The records that I request be disclosed are described as follows (please list date(s) of service, type of record and any other identifying information):
_____
_____

4. Please disclose the records identified herein to (provide name and contact information):
_____
_____

For Pick Up _____
Please Mail _____
Please Fax _____

5. I understand that I can revoke this authorization at any time, and that unless I revoke it sooner, it will automatically expire upon the disclosure made pursuant to this request. I recognize that any revocation that I make will not affect a disclosure that has already been made per this request.

6. I hereby release ELITE PHYSICAL THERAPY AND WELLNESS CENTER, and its employees and physical therapists from any and all liability for the disclosure of personal health information made in accordance with this request, including any subsequent unauthorized disclosure(s) made by a recipient. I agree to pay a $50.00 charge associated with the disclosure of records.

Individual (Signature) _____ Date of Birth_____

Print Name_____ Social Security Number _____

DATE: _____ Telephone Number_____