Dedicated to helping you live your best life.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

DATE: ____________________

PATIENT: ____

PATIENT DOB: ____

PATIENT PHONE NUMBER: ____

PERSON/DOCTOR(S) WE MAY DISCUSS YOUR SCHEDULE OR CARE WITH

NAME(S): ____

WORKER'S COMP PATIENTS

____ here by authorizes the release of protected health information such as number of cancelations and no show appointments resulting in non-compliance of therapy to my case manager ____ (name of person or referring provider) and any or all notes or bills pertaining to the payment of my treatment or continued care at another facility.

PROVIDER NAME/FACILITY: **Best Life Physical Therapy and Sports Medicine**

ADDRESS: **2404 Potters Rd. Suite 400**

CITY/STATE/ZIP: **Virginia Beach, VA 23454**

PHONE NUMBER: **(757) 961-5888**

FAX NUMBER: **(757) 340-6210**

By signing this authorization, I understand that I or the above signed, have the right to receive a copy of my records upon written request; anyone seeking information regarding my treatment at this facility has permission. You as the patient will be notified of any such person wanting information pertaining to your therapy with this office. This authorization is valid for one year from date of signature, unless otherwise revoked in writing. A copy of this authorization gives the same rights and permissions as the original.

PATIENT SIGNATURE: ____ DATE: ________________

PARENT/GUARDIAN SIGNATURE: ________________________________ DATE: ________________