MotionCare®
Movement for a better life

To request release of medical information, please
complete and sign this form and return it to:
5985 Rice Creek Parkway #104, Shoreview, MN 55126
FX: (651) 484-5663

Authorization for Release of Medical Record Information

Patient Information

Patient Last Name | First Name | M.I. | D.O.B

Street Address | Home Phone

City | State | Zip | Cell Phone

This Consent authorizes MotionCare Physical Therapy to release this information to:

Release Information

Name | Attention of:

Street Address | Suite/Room

City | State | Zip | Phone

This consent will expire twelve months following the date of signature on this form. You may cancel this consent, however, at any time. Your cancellation must be in writing, signed by you or on your behalf, and delivered to the address at the top of this form. Your cancellation will not be effective until we have received such cancelation and MotionCare can not be held responsible to the extent that we or others have acted in reliance upon the original consent.

You have the right to request restriction on the usage and disclosure of your protected health information for the purposes of treatment, payment or health care operations. We are not required to grant your request. If we do, however, MotionCare will be obligated to restrict the usage and disclosure of your protected health information as you have requested.

Our Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review our Posted Privacy Policy and/or obtain a copy of the MotionCare Patient Notice of Privacy Practices before you sign this consent.

We reserve the right to amend the terms of our Posted Privacy Policy. You may obtain a copy of the current policy by contacting our Compliance Officer at (651) 484-6735.

Patient/Spouse/Parent/Guardian Signature_____ Date_____

Printed name of the above signature_____ Relationship of signer, if other than Patient_____