AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

New Motion
Physical Therapy Inc., PS

9419 Coppertop Loop NE
Bainbridge Island, WA 98110
206-842-2428 FAX 206-842-2890

Patient's Name_______________

DOB ________________________

SSN: ________________________

I, ______________________________, Hereby Authorize **New Motion Physical Therapy, Inc**

to release to ______________________________, located at _________________________,
(name/facility) address

____, _________, _________________
city state zip

Ph number_(_________) __________________

medical information pertaining to physical therapy treatment.

Such disclosure shall be limited to the following medical records, a specific type of information, or dates of treatment:

Specific Medical Condition(s) ___________________________________or ☐ All

and/or Specific Timeframe(s) ___________________________________ or ☐ All

I also agree to pay any fees associated with copying, reviewing and mailing the above records. No fee is associated when records are released directly to another Medical Facility. Fees may apply when records are released to patient or non-provider Third Party.

Signature: ____ Date:__________________
Patient or Guardian

Witness: ____ Date:__________________
Signature Printed Name

If signed by other than patient, indicate relationship: ____________________________________

Proof of relationship required for guardian or legally appointed attorney. ___________________

The attached medical information pertaining to the patient named above is confidential and legally privileged. New Motion Physical Therapy, Inc. has provided it to, the facility stated above as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.