

**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: \_\_\_\_\_

Next Appointment: \_\_\_\_\_

I, \_\_\_\_\_, Hereby Authorize \_\_\_\_\_  
(name/patient) (name/facility)

to release to **New Motion Physical Therapy, Inc.**, 9419 Coppertop Loop NE, Bainbridge Island, WA 98110, FAX(206) 842-2890, phone (206) 842-2428, the following medical information contained in the patient's medical record.

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

Specific Medical Condition(s) \_\_\_\_\_

and/or Specific Timeframe(s) \_\_\_\_\_

Type of Records Needed:

- |  |  |
|--|--|
| <input type="checkbox"/> Operative Reports     | <input type="checkbox"/> Radiology Reports   |
| <input type="checkbox"/> Consultation Reports  | <input type="checkbox"/> X-Ray <input type="checkbox"/> MRI <input type="checkbox"/> Bone Scan |
| <input type="checkbox"/> Other (specify) _____ | other radiology reports (specify) _____  |

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. The facility stated above has provided it to New Motion Physical Therapy, Inc. 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.