Loudoun Sports Therapy Center
The Leader in Physical Therapy

## AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____
Address: _____ City: _____ State: _____ ZIP: _____

☐ By checking this box, I am indicating that I want these records to be released to myself and no other person or entity. If I am releasing to a different person or entity, their information is listed below:
Recipient's Name: _____ Relationship: _____
Recipient's Address: _____

Method of Delivery: ☐ Email ☐ Mail ☐ Fax ☐ Pick-Up

***By signing below, you understand that records sent via email carry some security risks once transmitted. By selecting email delivery, I authorize transmission to the email address listed below.***

Email/Address/Fax to be sent to:

_____

Please check each of the following Protected Health Information (PHI) that you would like released:

_____ Therapy Evaluation
_____ All Treatment Notes
_____ Itemized Bill / Statements

Date Range of Requested Records:
___ / ___ / ___ to ___ / ___ / ___
**OR** ___ All records

I understand that:

1. I may refuse to sign this authorization and that it is strictly voluntary.
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal regulations.
5. I may obtain a copy of this form after it is signed.
6. The person/entity listed above may obtain a copy of these records, but may not disclose them to anyone else without a separate written consent, unless allowed by federal law.

Please note that Virginia statutes allow a fee schedule as follows: $10.00 retrieval fee and $0.50 per page copied up to 50 pages. In the event this is an out of state request, the statue allows a $15.00 retrieval fee, $0.50 per page up to 50 pages, and an additional 10% shipping and handling fee. ***No fee will be charged for the patients first request for records released directly to themselves/guardian; applicable fees may apply to subsequent requests.***

I have read the above and authorize the disclosure of the medical records as stated.

_____ _____
Signature Date

_____ _____
Printed Name Expiration Date (1 year if none provided)

21355 Ridgetop Circle, Suite 310, Sterling, VA 20166
Phone: 703-450-4300 Fax: 703-450-5113
www.loudounsportstherapy.com