LIMITLESS
Physical Therapy & Wellness

Limitless Physical Therapy & Wellness

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Last Name of Patient: _____
First Name of Patient: _____
Date of Birth: _____

I hereby authorize medical providers and personnel of Limitless Physical Therapy to discuss and/or release my protected health information with:

_____ _____
Provider Name

This authorization shall be in force and in effect from_____until_____
at which time this authorization to use or disclose this protected health information expires.

Unless specified above, this authorization will expire 365 days from the date of signing.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that such revocation is not effective to the extent that the Clinic has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization.

Signature of Patient ----------

Date ----------