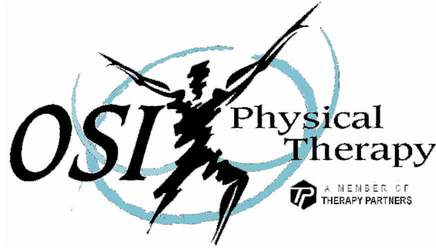

RECORD RELEASE AUTHORITY

Please Print

I, _________________________________ , Date of Birth: __________________________________

Hereby request that **___OSI Physical Therapy____**release my entire medical record to:

____

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____

____

OR

During the period from ______________________ to ____________________________

I understand that I may revoke this consent at any time and that this Release is valid for one year from the date signed, unless otherwise specified.

I understand that once information is released under this authorization, OSI Physical Therapy cannot prevent redisclosure of information.

Information not originally generated by OSI Physical Therapy will not be released. Such information must be obtained from the original source.

Signed: ____ Date: ____________________

Relationship/Reason if other than patient: ______________________________________

PLEASE FAX THIS REQUEST TO OUR MEDICAL RECORDS DEPARTMENT AT

651-748-2892 or MAIL TO: TPI 7541 9th STREET OAKDALE, MN 55128

ATTN: MEDICAL RECORDS DEPARTMENT

FOR OFFICE USE ONLY:

Mailed/Faxed on: ________________________ By ______________________________