Pacific
PHYSICAL THERAPY
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# Medical Records Release Form

Patient Name_____ Date of Birth _____/_____/_____

**I would like to**

- ◯ **Inspect ...**
- ◯ **Obtain a copy of ...**
- ◯ **Both inspect and obtain a copy of ...**

**my protected health information records from Pacific Physical Therapy.**

## Inspection

I would like to visually inspect the following:

- ◯ My complete record at this practice.
- ◯ My record at this practice for time period from _____ through _____ .
- ◯ A specific section of my record (please describe) _____

_____

I would like to inspect my records on the following date and time _____

## Obtaining a Copy

I would like to obtain a copy of the following:

- ◯ My complete record at this practice.
- ◯ My record at this practice for time period from _____ through _____ .
- ◯ A specific section of my record (please describe) _____

_____

I request the record in the form of:

- ◯ Readable hard copy
- ◯ A summary in lieu of receiving the complete record.
- ◯ Other format agreed to by Capstone Physical Therapy and myself: _____

Delivery

- ◯ I would like to pick up the copy of my records on the following date and time _____
- ◯ Please mail the copy of my records to _____

_____

*Your agreement will be requested in advance for any copying or mailing fees that the practice incurs to fulfil your request. This practice has the right to deny access, in whole or in part, to protected health information if the records are psychiatric notes, are a matter of national security or public health policy, are part of legal proceedings, were provided by a non-provider under promise of confidentially concerning their identity, or could place in danger your life or the lives of others.*

Signature _____ Date_____

*(Parent or Guardian if patient is a minor) • Relationship to patient (if signed by a personal representative of patient)*