HULSEY THERAPY SERVICES
Rehab & Sports Medicine

Authorization to Release Medical Records.

Patient's Name : _____ Patient's DOB :_____

Requestor Name : _____

Relationship to Patient if not the same : _____

Date of this request : _____

This shall serve as your official request to your PHI/Medical records copied and released.

For Dates of Services from _____ to _____

PHI Shall only be released to the following entity : _____
Recipient of PHI

Due to the specific requirements of the Health Insurance Portability and Accountability Act (HIPAA,) there are certain core elements required for all authorizations. Therefore, Hulsey Therapy Services PC requires the use of the included form – ***Authorization to Release Medical Records.***

It is also the policy of Hulsey Therapy Services, PC to receive prepayment in the amount of **$50.^{00}** for each submission/mailing of medical records.

Your request for the records will be processed upon receipt of both the

- $50.^{00} pre-payment, and
- Completed ***Authorization to Release Medical Records*** form.

By signing below, I release all restrictions and obligations concerning my PHI from Hulsey Therapy Services with respect to sharing of such information to above named recipient only. All other duties and obligations shall remain in full force and effect regarding protection of my PHI.

_____
Requestor Signature Date

For Business Office Use Only

Payment Received : ☐ Yes ☐ No Type of Payment Received : ☐Cash ☐ Check # _____ ☐ Credit

Received by : _____ Date : _____ Records Released Date :_____