Central Missouri Physical Therapy, LLC

dba PEAK Sport and Spine

3301 Berrywood Drive, Suite 204

Phone: (573) 449-6082 Fax: (573) 449-0401

www.peaksportspine.com

**Release of Medical Records**

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Patient’s Last Name, First Name, MI Date of Birth

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Address City State Zip

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Preferred Phone Number Alternate Phone Number

PEAK Facility Attended/Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| [ ]  **I authorize Central Missouri Physical Therapy to *release* information to:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Person/Facility/Healthcare Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PhonePlease Release: [ ]  Medical Records [ ]  Billing RecordsPeriods Covering: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Method: [ ]  Mail [ ]  Fax [ ]  EmailFax/Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  **I authorize Central Missouri Physical Therapy to obtain information from:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name of Person/Facility/Healthcare Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone/FaxPlease Release: [ ]  Medical Records [ ]  Billing RecordsPeriods Covering: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

PURPOSE FOR THIS REQUEST: (Check One)

[ ]  Healthcare [ ]  Insurance Coverage [ ]  Personal [ ]  Legal

I hereby release Central Missouri Physical Therapy, LLC, dba Peak Sport and Spine Rehab and all employees from any and all liability, claims or cause of action for providing my medical records, treatment and/or diagnosis, as well as account history to the parties requested. This authorization expires in six (6) months, unless sooner revoked in writing. This authorization is valid for release of information for treatment received prior to the signing of this form.

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Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature Relationship to Patient

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PEAK Sport and Spine Representative Signature Facility

Revised 1/1/2020