CHPT
Complete Hometown Physical Therapy

Mailing Address: P.O. Box 248
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Phone: 361-798-3500 Fax: 866-848-4059

# Patient Authorization for Release of Information

**Patient Name:** _____ **DOB:** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip:** _____

**I authorize Complete Hometown Physical Therapy to: (circle all that apply):**

☐ Exchange Information with ☐ Release Information to ☐ Obtain Information from

**The following Organization/Individual in regard to the above named patient:**

Name/Organization: _____

Address: _____ City: _____ Zip: _____

Phone: _____

**I hereby authorize this information to be exchanged in the following manner(s):**

☐ Verbal Only ☐ Written form only ☐ Both verbal and written

**Information to be exchanged / released / obtained (select all that apply):**

☐ Education records
☐ Evaluation/assessment/eligibility records
☐ Medical records
☐ Clinical records (including behavior analytic, psychological, physical, occupational, and speech therapies)
☐ **Other:** _____

**This information is to be used for diagnostic, treatment planning and continuity of care purposes only.**

Signed by: _____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Print Patient's Name | Date