



**ATLANTA FALCONS PHYSICAL THERAPY CENTERS
REQUEST FOR SPECIAL RELEASE OF PATIENT MEDICAL INFORMATION**

Federal Privacy Laws require our practice to obtain patient/parent/legal guardian permission to release, use and/or share protected patient medical information. By completing this form you are providing our practice with permission to share information with an entity that may not be covered under our standard patient medical information release during patient registration. We appreciate your time and cooperation.

PATIENT INFORMATION

Patient Full Name: Patient Date of Birth:
Patient Address: Patient Telephone #:

Please indicate any restrictions on information that we may share/release (including but not limited to drug and/or alcohol treatment or testing, HIV information and Mental Health Information).

The information will be released, used and/or shared for these specific reasons:

RECIPIENT INFORMATION

Recipient's Name: Telephone:
Company/Practice Name: Fax:
Recipient's Mailing Address:

AUTHORIZATION FOR SPECIAL RELEASE OF MEDICAL INFORMATION

I voluntarily give my authorization/permission for High Performance Physical Therapy Centers, LLC d/b/a Atlanta Falcons Physical Therapy Centers to release, use and/or share the medical information described in this document. I understand that once this information is released, used and/or shared, the entity that received it may share it again. If this happens, the information may no longer be protected under applicable privacy laws. I understand what type of information is going to be released, used and/or shared and how this is going to be done.

If I wish to withdraw my permission, I agree to put my request in writing and to send it to any operating Atlanta Falcons Physical Therapy Center. My letter will state who may no longer receive my patient medical information. I understand that if I send a letter withdrawing my permission, that letter cannot bring back any information that was already released, used and/or shared. I also understand that it will take time for the Atlanta Falcons Physical Therapy Centers to receive and process my request.

I have reviewed a copy of the Notice of Privacy Practices for Atlanta Falcons Physical Therapy Centers and I have read this document and fully understand its contents and significance.

Patient Signature: Name: Date:
Parent/Guardian's Signature: Name: Date: