ROSIPAL INSTITUTE FOR PELVIC THERAPY SOLUTIONS

5136 Village Creek Drive, Ste 502 Plano, TX 75093 Office 972-735-0920 Fax 972-735-0919
Email: rosipalinstitute@msn.com

Authorization to Release Medical Information

I, _____, hereby authorize Rosipal Institute for Pelvic Therapy Solutions to disclose the following information by ____ ***mail*** ____ ***fax*** ____ ***orally*** to:

Name (of person/entity to receive info): _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax Number: _____

Patients Name: _____ DOB: _____ Age: _____

For Purpose of : _____

My Authorization extends only to the information marked below:

_____ All Health Information
_____ Current Plan of Care
_____ Progress Notes
_____ Discharge Summary
_____ Record of visit for a specific Date (s). Specific dates include or are limited to:

_____

_____ Other (must be specific): _____

This authorization is given freely with the understanding that:

1. Any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this authorization is as valid as the original.
3. I may revoke this authorization at any time in writing, except where information has already been released.
4. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws.
5. This authorization will expire 1 year from the date of signature below unless prior date is specified.

_____ _____
Patient/Legal Representative Signature Date

_____ _____
Relationship to Patient *Expiration Date of Authorization*

_____ _____
Witness Signature Date