Medical Records Release/Request

Physical Therapy Institute
KINETIC
731 Bielenberg Drive, Suite 107
Woodbury, MN 55125
P: 651-730-7771
F: 651-730-7772

Patient Information:	Full Name (print): _____ Date of Birth: _____ Phone: _____
Health Information Released From:	☐ Kinetic Physical Therapy Institute **-or-** ☐ Name of Organization/Clinic _____ ATTN: _____ Phone: _____ Fax: _____
Health Information Released To:	☐ Kinetic Physical Therapy Institute **-or-** ☐ Name of Organization/Clinic _____ ATTN: _____ Phone: _____ Fax: _____
Medical Records Requested:	☐ Specific Date(s)/Year(s) of Treatment _____ ☐ Visit Notes _____ ☐ Operative Report(s) _____ ☐ EMG Report(s) _____ ☐ Radiology Report(s) _____ ☐ Other: _____ *Check to exclude records pertaining to any of the following (if not selected, they may be included):* ☐ Mental Health ☐ Drug/Alcohol Diagnosis/Treatment ☐ HIV/AIDS ☐ Genetic Testing
Delivery Method:	☐ Paper ☐ Fax ☐ Other (may not able to comply with a request): _____
Purpose for Release:	☐ Continued Care ☐ Litigation/Legal* ☐ Other* _____ *fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F.R§164.524

By signing this form, I understand that I am requesting the health information specified be sent to the third party listed above. I understand that I may revoke this request at any time in writing to Kinetic Physical Therapy Institute. The revocation will not apply to records already released. Kinetic Physical Therapy Institute will not condition treatment on whether I sign this authorization. I understand that the information can be re-disclosed by the third party listed above and once received it may no longer be protected by federal or state privacy laws. I am aware that some requests may be charged a fee as allowed by law.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Printed Name of Patient or Legally Authorized Representative: _____

If representative, specify relationship to the individual:

☐ Legal Guardian ☐ Power of Attorney ☐ Other_____