Bella Physical Therapy • 39-40 Broadway, Suite 4, 2nd Floor • Fair Lawn, NJ 07410
Phone: 201-791-0008 • Fax: 201-791-7111 • Email: bellaphysicaltherapy@gmail.com
www.bellaphysicaltherapy.com • Hours: Mon-Fri, 10 am to 8 pm • Closed Saturday and Sunday

MEDICAL RECORDS RELEASE FORM

Patient Name: ______________________________ Date of Birth: ____________________

I hereby authorize BELLA PHYSICAL THERAPY, PC (the Practice) to request any medical and other information on my behalf. I expressly request the Practice of full and complete disclose of protected medical information under HIPAA including the following:

This request and authorization applies to:

☐ All medical records, meaning every page in my record, including but not limited to: office notes, history and physical evaluations, inpatient, outpatient and emergency room treatment, progress notes, treatment plans, discharge summaries, consultations reports, test results, questionnaires/histories, and records received by other medical providers.

☐ Healthcare information related to the following condition, treatment, or dates:

____

☐ Other: ____

I understand the following:

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.

b. The information released in response to this authorization may be re-disclosed to other parties.

c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested herein. This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

____ ______________
Signature of Patient or Legally Authorized Representative Date