Triumph
Physical Therapy & Wellness Center

Patient Authorization for Release of Protected Health Information (PHI)

I, _____, hereby authorize Triumph Physical Therapy to disclose my Protected Health Information (PHI) to the individuals listed below. This authorization allows the release of information including, but not limited to, medical records, test results, treatment plans, and any other relevant health information.

I understand that the individuals listed below may use the disclosed information for the purpose(s) indicated and that they are obligated to maintain the confidentiality of my health information in accordance with the Health Insurance Portability and Accountability Act (HIPAA) regulations.

Patient Information:

Full Name: _____ Date of Birth: _____

Authorized Individuals:

Name: _____ Relationship to Patient: _____

Access Granted:

- ☐ Full Access to Medical Records
- ☐ Limited Access to Specific Records (Please specify): _____
- ☐ Access to Schedule/Cancel/Discuss Appointments on My Behalf
- ☐ Other (Please specify): _____

Name: _____ Relationship to Patient: _____

Access Granted:

- ☐ Full Access to Medical Records
- ☐ Limited Access to Specific Records (Please specify): _____
- ☐ Access to Schedule/Cancel/Discuss Appointments on My Behalf
- ☐ Other (Please specify): _____

By signing below, I acknowledge that I have read and understand the terms of this authorization and grant permission for the release of my protected health information as indicated.

_____ _____ _____

Signature of Patient / Representative Printed Name Date

Description of Personal Representative's Authority: _____