the manual touch
PHYSICAL THERAPY

Authorization for Release of Records

Patient Name_____

_____ **I have received the notice of privacy rights and responsibilities**.

Please list any insurance companies and/or health care providers that you would like to authorize release of your medical records to upon their request.

RECORDS RELEASE TO INSURANCE

I authorize The Manual Touch Physical Therapy to release pertinent clinical and account information to the following insurance companies to facilitate my reimbursement:

1._____

2._____

3._____

RECORDS RELEASE TO HEALTHCARE PROVIDERS

I authorize The Manual Touch Physical Therapy to release pertinent clinical and account information to the following practitioners:

1._____

2._____

3._____

VIDEO/PHOTOGRAPH CONSENT

I understand that the medical professionals at this facility may be taking pictures/videos progress for several purposes:

Marketing Purposes
Documentation of Functional Deficit
Research and Education Purposes

I understand that use of my case for any research will be done with facial & identifying features blocked out/concealed and that at any time I may revoke further photographic/video consent. I understand that before research concerning my case is submitted, I will be notified and allowed to review this data for approval. Photos used for marketing purposes may reveal your face unless specified not to.

Patient or Guardian Signature_____Date_____

Witness Signature_____Date_____

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