Submit by Email | Print Form

Campus Physical Therapy Center

901 Campus Drive Ste 213 Daly City, CA 94015 Tel: (650) 994-7800 eFax: (650) 240-1834

COST: The requestor shall pay in advance a $25.00 processing fee.

Name: _____ DOB:_____-_____-_____ Today's Date: _____-_____-_____

EXPLANATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code 56 et seq.

AUTHORIZATION

I hereby authorize **Campus Physical Therapy, Inc and / or Luis Araneda, PT, DPT,** to furnish to

_____*[name of the requestor]*

medical records and information pertaining to medical history, mental and physical conditions,

services rendered, or treatment of _____ *[name of patient]*

This authorization is limited to the following medical records: _____

_____*[i.e. medical illness, work injury,*

surgery] sustained on _____ *[date].*

USES

The requestor may use the medical record and type of information authorized only for the following purpose: _____

_____

_____

DURATION

This authorization shall become effective immediately and shall remain in effect until:

_____ - _____- _____ [date]

RESTRICTIONS

I understand that the requester may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY

I further understand that I have the right to receive a copy of this authorization upon my request.

I have received a copy of this document ____ *Yes* ____ *No* ____*Initials*

SIGNATURE

I have enclosed a $25.00 processing fee: _____ Yes _____ No

_____ _____

[name of patient, spouse, or financially responsible party] [signature]

If signed by other than the patient, please indicate relationship: _____

Date and Time: _____-_____-_____ ___:___ AM / PM