# HOHMAN REHAB & SPORTS THERAPY

## PATIENT AUTHORIZATION TO REQUEST OR RELEASE MEDICAL RECORDS

*Use this form to authorize records to be released FROM the source listed below TO the recipient listed below.*

### 1. PATIENT INFORMATION

| | |
|---|---|
| **Patient Full Name:** _____ | **Date of Birth:** _____ |

### 2. WHERE ARE THE RECORDS COMING FROM? Hospital, practice, provider, or Hohman Rehab location

| | |
|---|---|
| **Name of Hospital / Practice / Provider:** | |
| **Address / City / State:** | |
| **Phone:** | **Fax:** |

### 3. WHO SHOULD RECEIVE THE RECORDS?

| | |
|---|---|
| **Recipient Name / Facility / Organization:** | |
| **Email for Records:** | **Fax - Medical Facilities Only:** |

**Delivery:** Records are sent by secure email. Fax delivery is available only when the recipient is a medical facility.

### 4. WHAT RECORDS ARE YOU REQUESTING?

| | | | |
|---|---|---|---|
| ☐ Consultation Notes | ☐ Discharge Summary | ☐ Entire Record | ☐ History and Physical Notes |
| ☐ Progress Notes | ☐ Operative / Procedure Notes | ☐ Therapy Notes | ☐ Other: |

**Dates of Service Requested:** From: _____ To: _____

**Note:** Some facilities or specially protected records may require an additional authorization form.

### 5. AUTHORIZATION AND PATIENT ACKNOWLEDGMENT

- I authorize the source listed above to release the selected records to the recipient listed above.
- I understand therapy records may include medical history, diagnoses, medications, functional limitations, treatment, progress, and other health information documented as part of care.
- This authorization expires six months after the date signed unless I list an earlier date below.
- I may revoke this authorization in writing, except when action has already been taken.
- Information disclosed may be re-disclosed by the recipient and may no longer be protected by privacy law.
- Signing is voluntary. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on signing.
- The releasing provider may charge fees permitted by law. I may request a copy of this signed authorization.

### 6. REQUESTOR NAME AND SIGNATURE

| | |
|---|---|
| **Print Name (First, Last):** | **Signature:** |
| **Date:** | **Expiration Date (optional):** |

**Relationship if not the patient:** ☐ Parent / Guardian ☐ Health Care Power of Attorney ☐ Other: _____

**REQUIRED IDENTIFICATION**: Please include a clear copy of a valid government-issued photo ID when submitting this form. If the request is signed by someone other than the patient, include identification and documentation showing your authority to act for the patient. Requests submitted without the required documentation may be delayed.

**SUBMIT COMPLETED FORM AND COPY OF IDENTIFICATION TO:** Email: records@hohmanrehab.com | Fax: (352) 404-6909 | Mail: 236 Mohawk Rd., Clermont, FL 34715 | Walk in: Any location at www.hohmanrehab.com