

***AUTHORIZATION FOR THE RELEASE OF  
MEDICAL INFORMATION***

I HEREBY AUTHORIZE THE FOLLOWING PERSON OR ENTITY -  
\_\_\_\_\_ TO RELEASE MEDICAL  
REPORTS, TREATMENT NOTES, & PREVIOUS MEDICAL  
INFORMATION TO BIGFORK PHYSICAL THERAPY & SPORTS  
REHABILITATION, INC.

REQUESTED MEDICAL INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

SSN: \_\_\_\_\_

DOB: \_\_\_\_\_

SIGNED: \_\_\_\_\_

## Acknowledgment of Receipt of the NOTICE OF PRIVACY PRACTICES

This Acknowledgement of Receipt represents the following:

The patient signing below has received in writing a copy of, or has been provided a verbal overview of the Notice of Privacy Practices from Bigfork Physical Therapy & Sports Rehabilitation, Inc.

\_\_\_\_\_  
Signature of Patient or Representative

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date