



Kimberly Hilditch, PT, MSPT

14300 W. Granite Valley Dr., Suite E-21, Sun City West, AZ 85375
Phone: 623-546-6712 Fax: 623-546-6739

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

I hereby authorize Valley Rehabilitation of Sun City West, LLC to release my medical records;

To: _____

Address: _____

Phone Number: _____ Fax Number: _____

Purpose of Disclosure: _____

INFORMATION TO BE SENT - PLEASE CHECK ONE:

_____ ALL RECORDS
_____ OTHER (Be Specific): _____

I UNDERSTAND:

1. I may revoke this authorization unless it has already been acted on.
2. Treatment will not be conditioned on me providing this authorization, unless this provision of healthcare is solely for the purpose of creating protected health information for disclosure to a third party.
3. I may have a signed copy of this authorization.
4. This form must be ENTIRELY completed before information will be released.
5. This release is VALID for ONE YEAR from the signed date.

Signature of Patient/Guardian OR Personal Representative Date

Relationship to patient