

Genesis Physical Therapy Group
Authorization for the Release of Medical Records

Submit requests to Ciox Health at (FAX) 307-263-1505

**Allow up to 30-days for processing*

To check status of previously submitted requests, please call Ciox Health at 800-367-1500

PATIENT INFORMATION (Individuals over 18 years of age must complete their own form, except for legal Personal Representative situations)

First Name: _____ **Last Name:** _____ **Name at Time of Treatment (if different):** _____ **Date of Birth:** _____

Address/City/State/Zip: _____ **Phone #:** _____ **Email Address (optional):** _____

I AM REQUESTING MY RECORDS FROM (Select the Genesis PT Clinic(s) the patient attended)

- ☐ 227 Hwy 51, Ridgeland, MS 39157 ☐ 314 Airport Rd S, Pearl, MS 39208 ☐ 1707 West 20th St, Laurel, MS 39440 ☐ 4812 Lakeland Dr, Flowood, MS 39232
☐ 728 Clinton Pkwy #A, Clinton, MS 39056 ☐ 106 Highland Way #201, Madison, MS 39110 ☐ 128 Byram Bus Cntr Dr, Byram, MS 39272 ☐ 1055 US 49 S #B, Richland, MS 39218
☐ ALL OF THE ABOVE

RECIPIENT (This is the authorized person or organization who will receive the patient's information)

Recipient Name: _____ **Preference to Receive Information:** _____ **Email Address (optional):** _____
☐ Mail ☐ Fax ☐ Email

Recipient Mailing Address/City/State/Zip: _____ **Recipient Phone #:** _____ **Recipient Fax # (optional):** _____

INFORMATION TO BE RELEASED (If limiting disclosures, please describe)

	Begin Date	End Date	
Dates of Service:	_____	_____	I understand that this information is to be used for the purpose of: <input type="radio"/> Medical Treatment <input type="radio"/> Personal <input type="radio"/> Legal <input type="radio"/> Insurance <input type="radio"/> Disability <input type="radio"/> Other: _____

Information Requested:

- ☐ Appointment Dates ☐ Itemized Billing Statement ☐ Claim Forms ☐ Discharge Summary ☐ Progress Notes ☐ Patient Completed Paperwork ☐ Entire Medical Record ☐ Other: _____

SENSITIVE INFORMATION RELEASE: It is my full understanding that the records and communications to be disclosed WILL include sensitive information such as evaluation, habilitation /treatment information for mental health, developmental disabilities, alcohol or substance use/abuse or HIV/AIDS. CHECK BELOW FOR EXCLUSION ONLY. I understand that this health information may include sensitive information. By signing this form, I specifically authorize the release of sensitive information.

☐ Alcohol/Substance Abuse ☐ Mental Health ☐ Genetic Testing ☐ HIV/including AIDS ☐ Other: _____

EXPIRATION (When this authorization will end)

- ☐ Six (6) months (This option will apply if no other expiration is specified) ☐ On this specific date: _____

PATIENT SIGNATURE (Please sign and date below)

PATIENT RIGHTS: I understand that when I give my permission to release my health information or take my permission away from another facility or person, I must contact that party. If you wish to take your permission away, please send a written notice with signature and date of patient information that was to be released to: Genesis Physical Therapy Group, Privacy Officer, 308 Corporate Dr, Ridgeland, MS 39157. The notice should include detailed information as identified in the original authorization request. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand this form is voluntary and Genesis Physical Therapy Group will not condition my treatment on giving this authorization. I understand that I am entitled to receive a copy of this form after I sign it. I have carefully read and understand the Patient's Rights above, and do herein expressly and voluntarily authorize the disclosure of all the information requested in this authorization including the "Sensitive Information Release". I acknowledge this authorization with my signature below. **** If the Patient is a dependent or minor child, the legal guardian or child's parent must sign this form.**

Signature of Patient/**Patient's Personal Representative X _____ Today's Date: _____

PERSONAL REPRESENTATIVE INFORMATION: If you are signing this authorization as the Person's Personal Representative, please complete this section and attach a copy of the legal document establishing this authority (except for parent of minor, dependent child). Name of Patient's Personal Representative** (Print) _____

Relationship to the Patient: **Other than the parent of a dependent minor child, all other Personal Representatives must attach proof of their legal authority to this Authorization.

☐ Parent of Minor Child ☐ Legal Guardian** ☐ Power of Attorney** ☐ Other** _____