Authorization for Medical Records Release from Mid State Therapy

PATIENT NAME: _____

DATE OF BIRTH: _____ SS #: _____

ADDRESS: _____

_____

CITY: _____

STATE: _____ ZIP: _____

PHONE: _____

PLEASE RELEASE MY MEDICAL RECORDS FROM:

MID STATE THERAPY SERVICES, LLC
224 Pecan Park Ave, Suite 100
Alexandria, LA 71303
Phone: (318)427-7851 Fax: (318) 442-0562

- *Requests from insurances, attorneys, or other outside agencies will not be completed by our office. These requests should be made through Infostat.*

Please release a copy of my medical records, which includes but is not limited to, demographic face sheets, initial assessments, progress notes, daily visit notes, plan of cares, outcome measures, flowsheets, home exercise programs, case visit notes, and appointment history.

BY SIGNING BELOW, I DO HEREBY AUTHORIZE THE RELEASE OF MY MEDICAL RECORDS.

_____ _____
Signature of Patient (or Legal Guardian) Date

_____ _____
Printed Name of Patient (or Legal Guardian) Date