*In order for providers to be able to communicate with us (and/or each other) regarding your medical file under applicable state and federal law, we need to obtain a hand signed Medical Information Release Form ("MIRF") from you.*

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# Medical Information Release Form

The undersigned hereby grants permission to Coppola Physical Therapy to discuss any and all medical bill related information with any medical practitioner, hospital, facility, insurance company or any other agency/entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein.

The undersigned hereby authorizes any medical practitioner, hospital, facility, insurance company or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein, to release such information upon request to interested PARTIES (to be determined by Coppola Physical Therapy) for the purpose of communicating with Coppola Physical Therapy and/or for providers to be able to communicate with one another regarding your medical file.

**The undersigned understands that:**

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness, except psychotherapy notes, including treatment of alcohol or drug abuse.
- A copy of this form, including a facsimile, may be used in place of the original.

I acknowledge that I have read and understand this Medical Information Release Authorization.

**NOTE: Further, I authorize the disclosure of my protected health information in accordance with the terms in this Authorization.**

**Optional:** If it is necessary for someone other than your spouse to discuss your medical bills or finances with The Coppola Physical Therapy Group, please provide the individual's name below to appoint and authorize them to ac as your personal representative for this limited purpose: ("Personal Representative")

Patient’s Name: ______________________________

Patient’s Signature: ______________________________

Date: ______________