INSURANCE & PHYSICIAN RECORDS RELEASE FORM

Date: _____

Name: _____ Date of Birth: _____

By completing this form, you are providing consent to Fusion Bodywork, and/or its contractor's, to discuss your claim activity or medical records with the person(s) listed below:

Person(s)/Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Fax #: _____

Email Address: _____

~This authorization is valid until the claim has been resolved and full payment has been made~

I give Fusion Bodywork, and/or its contractor's, permission to release any or all of the following information:

_____ All Financial and claim information related to therapy bills or Claimant's Statement and Authorization.

_____ Provider name, date of service, total charge, total paid and date of payment.

_____ Insurance ID number and/or Social Security Number.

_____ Progress reports, photos, and recommendations for therapy treatments.

_____ SOAP charts for specific therapy sessions billed to insurance provider.

_____ Intake forms and correspondences.

_____ Personal Injury Protection Level and Ledger

Under no circumstance can Fusion Bodywork, and/or its contractor's, release medical/bodywork/confidential information obtained from your physician or provider of service to you or anyone unless previous consent has been provided.

Client/Insured Guardian Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____

Insurance Provider: _____ Claim No: _____

www.Fusion-Bodywork.com
(801)554-7991

865 East 4800 South, ste 240
Murray, UT 84107