Gymfit Physical Therapy & Wellness

MAILING ADDRESS:
Gymfit Physical Therapy & Wellness
1296 Cronson Blvd.,#4365 Crofton, MD 21114
Billing Direct: 301-615-0553
Office: 301-818-5527

RECORDS RELEASE REQUEST

Date: _____/_____/_____ Duplication Fee (Office Use Only): $_____

Patient Name: (Please print clearly): _____ Patient DOB: _____/_____/_____
First M.I. Last

As required by the Health Insurance Portability and Accountability Act of 1996, Gymfit Physical Therapy & Wellness may not use or disclose your health information without your authorization except as provided in our Notice of Privacy Practices. Your signature on this form indicates that you are giving permission for the uses and disclosures described below.

If other than patient, print the name of the person requesting release of physical therapy records on behalf of the patient named above, and specify relationship to patient.

Requestor's Name: _____ Relationship to patient: _____
First M.I. Last

By signing below I give permission to the Gymfit Physical Therapy & Wellness to release copies of (check one):

☐ My PT records ☐ My child's PT records ☐ The PT records of the patient named above whom I am legally authorized to represent

I authorize and request the records to be released/sent to: (please print clearly)

Name: _____

Address: _____
Street City State Zip Code

OR FAX #: _____

I understand that:

- I have the right to request a copy of this form after I sign it, as well as inspect or copy any information to be used and/or disclosed under this authorization.
- If the person or organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- A copy of the patient record will be released. The original patient record remains the property of the Gymfit Physical Therapy & Wellness and will be maintained in accordance with Maryland state laws.
- I will be charged a fee for duplication of the information.

I authorize and request the release of the following information (please check all that apply):

THE STANDARD ADMINISTRATIVE FEES ARE AS FOLLOWS: $.90 PER PAGE.
PLEASE NOTE: NO CHARGE FOR BOWIE PATIENT REQUESTS THROUGH DECEMBER, 31, 2025 DUE TO OFFICE CLOSURE.

Physical Therapy record (treatment notes, plans)	**Medical Bills**
☐ Specific Case/Time Period: _____	☐ Specific Case/Time Period:_____
☐ Full History	☐ Full History

To submit this request please complete and fax this form to 301-615-0553 or email billing@gymfitpt.com.

Processing your request for copies of records and medical bills takes approximately FIVE **(5) WORKING DAYS AFTER RECEIPT OF THE AUTHORIZATION FORM AND PAYMENT**. *Forty-eight hour expedited processing is available for an additional **$20.00 fee** plus the standard $.90 per page (Contact us directly if you would like your request expedited).* **Please call our office and make payment or make checks payable to Gymfit Physical Therapy & Wellness and mail to the attention of Gymfit Billing Department. To reach us by telephone, call or fax 301-615-0553. Our billing department can be reached directly at 301-615-0553.**

Patient or Requestor's Signature Date