Dear Valued Patient,

This notification is to inform you that Score Physical Therapy practice and office at 1350 41st Avenue # 100 Capitola, CA 95010 will be sold and under new ownership effective June 1, 2020. The new owner, OrthoNorCal will begin seeing patients on June 1, 2020. Please visit their website (https://www.orthonorcal.com/pt/) for more information or call the same clinic number at (831) 706-2085.

In order for this new team to be familiar with your physical therapy care and fully prepared to treat you from their first day in the office, they will need a returned authorization form (enclosed) to access and review your records. We have confidence in OrthoNorCal and hope you will consider continuing your care at this facility.

If, for whatever reason, you decide to be treated elsewhere, our team at Score Physical Therapy will be happy to provide your new physical therapist with copies of the necessary records from your file. If that is your preference, please sign and return the enclosed authorization form with your instructions on where to send your records via one of the methods below.

Mailing Address: 1106 Walnut Street, Suite 110, San Luis Obispo, CA 93401
Phone Request: 805-250-5393
Email Address: recordsrequests@movementforlife.com
Fax Request for completed form: 805-788-0845

You may receive two statements, one from:

Score Physical Therapy
1106 Walnut St Ste 110
San Luis Obispo, CA 93401

And one from:

OrthoNorCal

Please remit each payment to the address associated with each statement.

We regret that we will not be continuing to serve the community, but feel grateful for the many rewarding experiences and memorable patients. Best wishes for your health and happiness.

Sincerely yours,

Score Physical Therapy

Attention: Medical Records
1106 Walnut Street, #110
San Luis Obispo, CA 93401
Phone: (866) 387-7778
Email: recordsrequests@movementforlife.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if required by Law or Rules

1. **Patient's Printed Name**

   ____
   Last First Initial Or Other
   Date of Birth: ____/_____/____

2. **Score Physical Therapy will only disclose the protected health information you want disclosed**. Check only one box to tell Score Physical Therapy the specific information you want disclosed/released:
   - ☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)
   - ☐ Limited information (complete ALL Sections)

3. **Complete only if you selected "limited information". Please initial all that apply**:

   _______ Evaluation/Examination _______ Attendance _______ Correspondence re: your Physical Therapy Services
   _______ Past Medical History _______ Treatments _______ Physical Therapy Bill / Statement
   Other ____

4. **Complete <u>only</u> if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name**:

Spouse	____________________	Attorney	____________________
Parent	____________________	Employer	____________________
Friend	____________________	School	____________________
Self	____________________	Other	____________________

5. **Check only one box indicating how long Score Physical Therapy can use this authorization:**
   - ☐ Disclose my information indefinitely (as long as Score Physical Therapy has custody of my files)
   - ☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/____

6. **Please initial all items below indicating that you have read and understand the rights or information below:**

   _______ I understand that this authorization does not expire unless I have indicated an expiration date above
   _______ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
   _______ I understand that if I give authorization I may revoke it at any time by notifying Score Physical Therapy in writing
   _______ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
   _______ I understand that if Score Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
   _______ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
   _______ Score Physical Therapy will not be compensated for using or disclosing my PHI, unless related to treatment / payment procedures, without specific permission from me after full disclosure of purpose and intent

______________________________ or ______________________________
Signature of patient Signature of Parent or Authorized Representative Date
(Indicate the Relationship)

You May Refuse to Sign this Authorization