



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*

HIPAA 143a-Authorization for Release of PHI 10-28-08

(1) Patient's Printed Name:

Last

First

(2) Restore and Revitalize Physical Therapy will only disclose the protected health information you want disclosed. Check only one box to tell Restore and Revitalize 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)
- ALL records regarding my care at Restore and Revitalize Physical Therapy to any requesting party (skip 3 and 4)

(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 Other _____

(4) Complete only 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: _____
 Other: _____ Other: _____

(5) Check only one box indicating how long Restore and Revitalize Physical Therapy can use this authorization:

- Disclose my information indefinitely (as long as Restore and Revitalize 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 Restore and Revitalize 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 Restore and Revitalize 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
- _____ Restore and Revitalize Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

Client Signature _____ Date: _____

You May Refuse to Sign this Authorization