Authorization for Physical Therapy Specialties to Use/Disclose Protected Health Information

I, ______________________________, authorize Physical Therapy Specialties to release the following information for (reasoning i.e. P.E. excuse, facilitate reimbursement, facilitate treatment):

____

Description of information to be used/disclosed (be as specific as possible):

- ☐ All records
- ☐ X-ray films (describe): ____
- ☐ Other (describe): ____

Delivery Preference:

- ☐ Fax
- ☐ Pickup
- ☐ Mail (please confirm address): _______________________________________
  ____

If the information to be used/disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

_______Drug/Alcohol diagnosis _______HIV/AIDS information ______Mental Health Information

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, mental health information and genetic testing information.

Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care service is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in the written authorization. Any use or disclosure already made with your permission cannot be undone. To revoke this authorization, please send a written statement to Physical Therapy Specialties 3908 Valley Avenue, Suite B, Pleasanton CA, 94566. To revoke orally, please call our Release of Information Department at 925-417-8005.

I have read this authorization and understand it. Unless revoked, this authorization expires in 180 days.

____ Date: ________________________

(Patient or Patient Representative signature)

____

(Description of Patient Representative)