



HIPAA AUTHORIZATION FORM

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Telephone () _____

I hereby authorize the release and disclosure of the protected medical information described below to the following provider, organization, or individual:

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Telephone () _____ Fax () _____

AUTHORIZATION FOR RELEASE OF INFORMATION (Initial)

_____ I hereby authorize the release of my complete physical therapy medical records.

EFFECTIVE DATES

- Indefinitely
- From _____ to _____

I understand that my medical records are protected by the Federal Confidentiality Regulation as well as the provisions of HIPAA and cannot be disclosed without my written authorization. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand the information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Patient Signature _____ Date _____