United Physical Therapy

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT FOR REQUIRED SIGNATURES

Patient Name:_____Date of Birth:_____
Patient Address:_____
City_____State_____Zip_____
Phone#_____Alternate Phone#_____

Disclosure of protected health information is made at my request for: *(circle one)*

Change of Insurance Referral Change of Physician PHI Other_____

Records to be disclosed: Describe what specific records may be disclosed/circle all that apply
All Records Records from (date)_____to (date)_____
Evaluation/Progress Notes Discharge Summary Billing Records Physicians Script

All records mean all protected health information in a designated record set, which may include, but is not limited to, patient family histories, genetic information, inpatient/outpatient records, medical, dental, pharmaceuticals (medications), hospital, physician or other healthcare providers' records, office notes, narrative summaries, correspondence to/from/about me, diagnostic testing results, bills, statements & invoices for services and information from all other health care providers used for your care and treatment in the hospital or facility. If you received psychiatric or psychotherapy services, alcohol/chemical substance abuse treatment or treatment for HIV/AIDs which are federally protected as confidential, those records will be included unless you specifically exclude them in writing prior to disclosure.

Persons, facility or class of persons who are authorized to disclose (provide) the records/information:
The facility / hospital named above
Other A Joint Effort PT
Persons, facility or class of persons who are authorized to receive the records/information:
Physician/hospital/other healthcare provider name United Physical Therapy
Attorney/Law Firm_____
Address 12570 Old Seward Hwy. #202
City/State/Zip Anchorage, AK 99515
Phone# 907-222-2886
Please complete more than one form if multiple disclosures to multiple providers are requested.

I authorize the disclosure of the information described. I understand that if the person or entity that receives the described records/information is not a health care provider or health plan covered by federal privacy regulations, the records/information may be redisclosed and no longer protected by those regulations. I also understand that certain records may be protected by federal or state law and I am requesting that any and all such protected records be released under this authorization. If I revoke this authorization, it will have no effect on actions taken or information already sent as authorized by this form. I also understand that the hospital/facility will not condition treatment, payment, enrollment or eligibility on whether I sign the authorization. I also understand that I may have a copy of this form after I sign it. I also permit disclosure of information upon presentation of a use of a photocopy of this authorization. I understand that I have the right to revoke this authorization. I may do so by delivering or mailing a written revocation to this facility/hospital, any other healthcare provider or attorney or law firm if named above. Unless otherwise revoked, the authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, event or condition, this authorization will expire 1 (one) year from the date signed.
I have read and understand this form. I am the patient listed or am authorized to act on behalf of the patient as the patient's personal representative.

_____ _____
Signature of Patient or Patient Representative Date
Personal Representative's Relationship/Capacity to Patient_____
Printed Name of Personal Representative_____
Printed Address & Telephone Number of Personal Representative_____