QOPT Authorization for the Release of Protected Health Information

Patient Information

Patient Name:______________________________ Date of Birth: ____________ Phone Number: ______________ _____

Address: ___________________________City: _______________________ State: ______ ZIP Code: _____________

Individual/Organization Authorized to Release PHI

Patient Name:____ Organization: Quinn Orthopedic Physical Therapy

Part III: Individual/Organization Authorized to Receive PHI

Name/Organization: _______________________________________ E-mail: _____________________________________

Address: ________________________________ _City: _ ___________________State: ______ ZIP Code: _ ____________

Phone Number:____________________________ Fax Number(if applicable): ___________________________________

Patient Authorization

I, ________________________________, hereby authorize the use or disclosure of my health information as described above for the purposes listed. I understand that this authorization is voluntary and valid for one year from the date of my signature unless I revoke it in writing or indicate otherwise.

I understand that I have the right to revoke this authorization at any time by providing written notification to the party named in Part II. The revocation will take effect upon receipt and will prevent further release of my health information from that date forward. However, I understand that actions taken in reliance on this authorization before the revocation will not be affected.

I acknowledge that I am signing this authorization voluntarily and that my healthcare treatment, payment, or eligibility for benefits will not be impacted whether I choose to sign this authorization or not.

I also understand that the party named in Part III is prohibited from re-disclosing my health information unless I provide written authorization or as specifically permitted by law, such as under California Code §56.10.

If the party named in Part III is not a HIPAA-covered entity or business associate as defined in 45 CFR §160.103, I understand that the health information disclosed may no longer be protected under federal and state privacy regulations.

I acknowledge that I have the right to receive a copy of this authorization and that fees may be charged to cover the cost of releasing my health information.

Additionally, I understand that my substance use disorder records are protected under federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written authorization.

Patient or Personal Representative

Signature:____ Date: ____________________

Name:____Relationship to Patient: ___________________________________

If Signed by Representative (Signature of Witness): ____

For Office Use Only

Received by:________________________________Date Received: _______________ Date Completed:_______________