Patient Consent & Authorization for Release of Protected Health Information

Patient Information:

Patient Name:_____ Date of Birth: _____ Phone Number: _____

Address: _____City: _____ State: _____ ZIP Code: _____

Records Request By

Name: _____ E-mail: _____ Phone Number: _____

Recipient Information **Send by** ❑ Pick up ❑ E-mail ❑ Mail ❑ Fax

Name/Organization: _____ E-mail: _____

Address: _____City: _____State: _____ ZIP Code: _____

Phone Number:_____ Fax Number(if applicable): _____

Type of Records: ❑ Billing ❑ Medical ❑ All Records

Records Requested: _____

_____

Reason for Disclosure: _____

_____

Patient Authorization

I, _____, hereby authorize Quinn Orthopedic Physical Therapy to release the information as described above. I understand that, per my request, this authorization will permit the above-named parties to use or disclose the identified health information for the purpose beyond treatment, payment, or healthcare operations as provided by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that I may revoke this authorization at any time by providing written notification to Quinn Orthopedic Physical Therapy.

The revocation will be effective on the date it has been received and processed by Quinn Orthopedic Physical Therapy. I understand that the revocation does not apply to actions taken in reliance upon the authorization prior to the effective date of the revocation. I also understand that I do not have to sign this authorization to receive treatment, pay, or to enroll or be eligible for benefits. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the named recipient, and may no longer be protected by HIPAA's privacy rules after the authorized disclosure.

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:_____