# AUTHORIZATION FOR RELEASE OF INFORMATION

***Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required or Permitted by Law or Rules***

Patient's Printed Name: _____
Last First Initial or Other

Date of Birth: ___/___/___ Social Security Number: _____/_____/_____

Address: _____
Street or P.O. Box City State Zip Code

Phone: (Day) ____/_____ (Evening) ____/_____ (Cell) ____/_____

**Please choose one option below:**

□ **I hereby authorize Capitol Physical Therapy to release all records regarding my care to any *written* request for all dates of service as long as it retains my files**

□ **I only authorize the release information to the individuals/entities *identified below by name*:**

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

**Capitol Physical Therapy May Release the Information Below As Long As It Retains My Files:**

□ **Yes** □ **No** **If No, Please Specify Duration or Expiration Date:** _____

**Please initial all items authorized for use or disclosure:**

_____ All Records May Be Released Related to My Care at this Facility

**OR only**:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatment _____ Fees for Services _____Other _____

**Please initial all items below indicating that you have read and understand the rights or information below:**

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying this Capitol PT in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if Capitol PT requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ Capitol PT will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtain to the patient after full disclose of purpose and intent

_____ or _____
Signature of Patient Date Signature of Parent or Authorized Representative Date
(Indicate the Relationship)

***You May Refuse to Sign this Authorization***


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