AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(1) Patient's Name: (please print)

_____
Last First Initial or Other

Date of Birth: ____/_____/___

(2) Elevate Physical Therapy & Sports Medicine will only disclose the protected health information you want disclosed.

Check only one box to tell Elevate Physical Therapy & Sports Medicine the specific information you want disclosed/released:

☐ ALL records regarding my care at Elevate Physical Therapy to any requesting party

☐ Limited information: _____

(3) I, the undersigned, authorize and request Elevate Physical Therapy & Sports Medicine to release to:

Person/organization: _____
Address _____
City: _____ State _____ Zip _____
Phone: _____ Fax: _____

(4) Check only one box indicating how long Elevate Physical Therapy & Sports Medicine can use this authorization:

☐ Disclose my information indefinitely (as long as Elevate Physical Therapy & Sports Medicine has custody of my files)

☐ Disclose my protected health information for the following period beginning ___/___/_____ and ending ___/___/_____

(5) 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 Elevate Physical Therapy & Sports Medicine 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 Elevate Physical Therapy & Sports Medicine 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.
_____ Elevate Physical Therapy & Sports Medicine will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent.

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