# AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

*This authorization complies with 45 CFR § 164.508(c) (HIPAA)*

I, _____, hereby authorize Southern Maine Physical Therapy and its employees to furnish, discuss and release all information and records requested below in writing covering findings, treatment rendered, and opinions as to my condition as authorized below.

- To an insurer, managed care organization, governmental agency or other third party that is responsible for payment or arranging for payment of my healthcare for the purpose of Southern Maine Physical Therapy billing and receiving payment for the healthcare services provided to me.
- To any hospital ambulatory surgical facility or other healthcare facility or healthcare practitioner for the purpose of providing proper medical treatment or healthcare to me.
- To members of my family for the purpose of advising my family members regarding my diagnosis, prognosis and treatment while a patient of Southern Maine Physical Therapy.

**Purpose of this Authorization to Release Health Care Information:**

- to develop and coordinate my treatment plan
- to communicate contraindications, precautions, progress and/or recommendations for return to work, athletic/sports activities or other functional activities
- to pursue legal/liability claims

**Records authorized to be released:**

- Examination/Evaluation medical records created by Southern Maine Physical Therapy.
- All medical treatment records
- Diagnostic tests (MRI, X-rays, CT Scan, EMG/NCV testing, and any other diagnostic tests) in my records regardless of who created the records.

**Duration of Authorization::**

*The authorization shall remain in effect for 12 months of start date of treatment at Southern Maine Physical Therapy or until I revoke this Authorization, whichever comes first.*

**I UNDERSTAND:**

- I understand, and voluntarily consent, to disclosure of information to the extent stated above. A copy of this Authorization shall have the same force and effect as the original. Subsequent disclosures may be made under this Authorization.
- **Refuse to Authorize Disclosure** of health care information, and that I may refuse or revoke the Authorization, I understand that such refusal or revocation my result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance coverage or benefits, or other adverse consequences. Further, I understand that such revocation may be the basis for denial of health care benefits or other insurance coverage or benefits.
- The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.



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- **Revoke of Authorization** at any time by executing a written revocation, subject to the rights of any individual who acted in reliance on the authorization prior to receiving notice of revocation. This revocation will be signed and dated by me and will state that all or part of this authorization is revoked.
- Upon my request, I am entitled to inspect or copy information disclosed hereunder, pursuant to C.F.R. 164.524.

- I understand that treatment will not be denied if I refuse to sign this authorization.
- No enrollment or eligibility for benefits, treatment or payment is intended or expected to be conditioned upon this Authorization.

_____ _____

Patient's Signature Date

_____ _____

Parent or Guardian's Signature Date

***YOU ARE ENTITLED TO A COPY OF THIS CONSENT.***
***A COPY WILL BE PROVIDED TO YOU ON REQUEST WITHOUT CHARGE***

## ACKNOWLEDGEEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

I understand that Southern Maine Physical Therapy regards the safeguarding of health information as an important duty. I understand that the elements of this consent are required by state and federal law for my protection and to ensure my informed consent to the use and disclosure of health information necessary to support my relationship with Southern Maine Physical Therapy.

I acknowledge that a copy of the Notice of Privacy Practices for Southern Maine Physical Therapy, has been made available to me and that I had an opportunity to ask questions about these practices.

_____

Name of Patient or Authorized Representative (please print)

_____ _____

Signature of Patient or Authorized Representative Date